STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G238 (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED B. WING NAME OF PROVIDER OR SUPPLIER TIBSTRA HOUSE STREET ADDRESS, CITY, STATE, ZIP CODE 271 EAST 161ST STREET SOUTH HOLLAND, IL 60473 STREET ADDRESS, CITY, STATE, ZIP CODE 271 EAST 161ST STREET SOUTH HOLLAND, IL 60473 (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 CORRECTIVE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COM COMPLAINT INVESTIGATION W 000 INITIAL COMMENTS W 000 W 000 V 000 9/20 W 102 483.410 GOVERNING BODY AND W 102 9/20			H AND HUMAN SERVICES				-	APPROVED . 0938-0391
Image:	STATEMENT	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE SU COMPLE	URVEY ETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE TIBSTRA HOUSE STREET ADDRESS, CITY, STATE, ZIP CODE (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) COM W 000 INITIAL COMMENTS W 000 W 000 W 000 VW 000 VW 000 W 102 VW 102 9/20			14G238	B. WI	۱G			
TIBSTRA HOUSE SOUTH HOLLAND, IL 60473 (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) COM W 000 INITIAL COMMENTS W 000 W 000 W 000 W 000 V000 V0000 V000 V000	NAME OF PI	PROVIDER OR SUPPLIER						
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COM COMPLAINT INVESTIGATION W 000 INITIAL COMMENTS W 000 W 000 W 000 V 000	TIBSTRA	A HOUSE						
COMPLAINT INVESTIGATION Complaint #1192523 IL 54146 W 102 483.410 GOVERNING BODY AND W 102 9/20	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	(X5) COMPLETION DATE
Complaint #1192523 IL 54146 W 102 W 102 9/20	W 000		TS	W	000			
W 102 483.410 GOVERNING BODY AND W 102 9/20		COMPLAINT INVE	ESTIGATION					
	W 102			W	102			9/20/11
The facility must ensure that specific governing body and management requirements are met.								
This CONDITION is not met as evidenced by: Based on record review and interview, the facility's governing body failed to provide adequate direction for staff to promote the safety for 1 of 1 clients, R1, who alleged a staff person had sexual contact with the client , due to the failure to immediately report this allegation to the Administrator and place sufficient safeguards for the clients. The facility failed to ensure: 1. The alleged staff did not have contact with this client or others during the course of the investigation 2. Direct care failed to immediately report the allegation of sexual contact to the Administrator 3. Medical personnel assessed R1 for evidence of sexual contact 4. During the course of the investigation the alleged staff was allowed to transport and attend an activity outside the facility with clients from this facility 5. The facility policy for abuse and neglect includes any medical evaluation or the protection of clients related to contact with the alleged perpetrator. Findings include: Refer to deficiencies cited at:		Based on record re facility's governing adequate direction for 1 of 1 clients, R had sexual contact failure to immediate Administrator and p the clients. The face alleged staff did no or others during the Direct care failed to allegation of sexua 3. Medical personn of sexual contact 4 investigation the all transport and atten with clients from th for abuse and negl evaluation or the per contact with the alle	eview and interview, the body failed to provide for staff to promote the safety 1, who alleged a staff person with the client , due to the ely report this allegation to the place sufficient safeguards for sility failed to ensure: 1. The thave contact with this client e course of the investigation 2. b immediately report the I contact to the Administrator hel assessed R1 for evidence b. During the course of the leged staff was allowed to an activity outside the facility is facility 5. The facility policy ect includes any medical rotection of clients related to eged perpetrator.					
								(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following 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 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/25/2012

		AND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE SI COMPLE	JRVEY TED
		14G238	B. WI	NG _			C 3/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
TIBSTRA	HOUSE				271 EAST 161ST STREET SOUTH HOLLAND, IL 60473		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 102	Continued From pa	ige 1	W	102			
		ning body and management plicy and operating over facility					
	W122 - Condition o Protections	of Participation - Client					
W 104	W331 - Clients mus accordance with the 483.410(a)(1) GOV		W	104			9/20/11
		y must exercise general policy, ing direction over the facility.					
	Based on record re failed to ensure the included what actio an allegation of sex the clients status m suspended employe alledged abuse or r clients during the co impacting 1 of 1 R1 contact with her and	s not met as evidenced by: eview and interview, the facility ir policy on abuse and neglect ns should be taken: 1. when cual abuse is made to evaluate nedically 2. To address a ee who is the subject of neglect, allowed contact with ourse of the investigation I, who alleged staff had sexual d had the potential to impact 6, R7, R9, R10, R11, R12, 6.					
	Findings include:						
	7/28/11, is a 57 yea	sician's Orders Sheet dated ar old female whose diagnoses I Retardation and Down					
	The facility policy tit	tled Abuse and Neglect dated					

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		AND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391
STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY TED
		14G238	B. WI	NG _			C 3/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
TIBSTRA	HOUSE				271 EAST 161ST STREET SOUTH HOLLAND, IL 60473		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 104	1/31/08 defines Sex sexual contact, sex coercion, or sexual Sexual abuse includ fondling, body expo sexual acts with the harassment, etc." T states, "Obtain copi that pertain to the ir statements, medica photographs, and a The policy does not action is to be taken abuse occurs. Review of an Allega dated 8/8/11 compli- notes R1 after retur reported E5, Direct touched her private breasts and vaginal Record review of R information R1 had person (nurse or ph Interview with E1, C on 8/19/11 at 10:45 been seen medicall Interview with E2, E at 2:25pm acknowle abuse/neglect does medically action is t	xual Abuse as, "Any act of tual penetration, sexual exploitation of an individual. des, but is not limited to: osure, rape, engagement in e persons served, sexual The General Procedure section ies of documents or records incident, including written al reports, individual records, any applicable evidence." t define what specific medical in when an allegation of sexual ation of Abuse/Neglect Report leted by E7, Administrator, rning from work on 8/8/11 Service Person (DSP) had e areas on 8/6/11 including her l area.	W	104			

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		AND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	JRVEY TED
		14G238	B. WI	NG _			C 3/2011
NAME OF P	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
TIBSTRA	HOUSE				71 EAST 161ST STREET SOUTH HOLLAND, IL 60473		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 104	1/31/08 under PRO Procedures, "Any eneglect will be immu until completion of the The policy does not between a suspend nor does it address employee is on faci On 8/31/11 at 10:45 informed surveyor ff (DSP), had been te employee who was sexual abuse had be the facility bus with church on 8/28/11, residents and drove before leaving facilit E5 had been told he the residents. E7 st on 8/9/11 he was to the second suspens results of an independ him he is off the scl specifically tell him the residents. E7 wo on Abuse and Negl employee's contact "No, it is not that sp have received train suspended employed E7 stated the 2 stat believes received train stated he discussed of E5's termination	CEDURES C. General employee accused of abuse or ediately suspended with pay the investigation." t address the issue of contact ded employee and residents s staff actions if a suspended	W	104			

Facility ID: IL6012009

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		I AND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	TED
		14G238	B. WI	NG _			C 3/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
TIBSTRA	HOUSE				271 EAST 161ST STREET SOUTH HOLLAND, IL 60473		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 104	suspended employe	ee contact with residents or if a suspended employee	W	104			
W 122	483.420 CLIENT PI	ROTECTIONS sure that specific client	W	122			9/20/11
	Based on record refacility's governing P adequate direction of for 1 of 1 clients R1 had sexual contact failure to immediate Administrator and p the clients. The faci alleged staff did not or others during the Direct care failed to allegation of sexual 3. Medical personne of sexual contact 4. investigation the alle transport and attents with clients from thi for abuse and negle evaluation or the pr contact with the alle resulted in an Imme Findings include: On 8/31/11 at 12:20	is not met as evidenced by: eview and interview, the body failed to provide for staff to promote the safety , who alleged a staff person with the client , due to the ely report this allegation to the blace sufficient safeguards for ility failed to ensure: 1. The t have contact with this client e course of the investigation 2. b immediately report the contact to the Administrator el assessed R1 for evidence . During the course of the eged staff was allowed to d an activity outside the facility s facility 5. The facility policy ect includes any medical totection of clients related to eged perpetrator. This ediate Jeopardy.					

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		HAND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	JRVEY TED
		14G238	B. WI	√G			C 3/2011
	PROVIDER OR SUPPLIER			2	REET ADDRESS, CITY, STATE, ZIP CODE 71 EAST 161ST STREET SOUTH HOLLAND, IL 60473		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 122	suspended employ E5, Direct Support grounds prior to con The 2 staff present report the presence the appropriate per bus along with R1, R10, R11, R12, R1 church. E5 attended and E9 and drove t before leaving the f This lack of ensurin alledged sexual abu facility residents po and well being of th an Immediate Jeop E7, Administrator, v Jeopardy on 8/31/1 On 9/6/11 at 2:37pr notified that the Imme removed. Refer to deficiencies W104 - The governe exercise general po W149 - Develop an prohibit abuse W154 - Must have are investigated W155 - Must preve	ee for alleged sexual abuse, Person (DSP) was on facility mpletion of the investigation. E4 and E9, DSP's, did not of E5 on facility grounds to sonnel. E5 drove the facility R2, R3, R4, R5, R6, R7, R9, 3, R14, R15, R16 and E9 to d church with the residents the bus back to the facility facility grounds. Ing a suspended employee for use did not have contact with thetentially jeopardized the safety he residents. This resulted in bardy. was notified of the Immediate 1 at 12:20pm. Im E7, Administrator, was mediate Jeopardy was	W	122			

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		I AND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY TED
		14G238	B. WI	NG _			C 3/2011
NAME OF F	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
TIBSTR	A HOUSE				271 EAST 161ST STREET SOUTH HOLLAND, IL 60473		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 122		-	W	122	2		
W 149	accordance with the 483.420(d)(1) STAI CLIENTS	eir needs FF TREATMENT OF	W	149)		9/20/11
	policies and proced	evelop and implement written lures that prohibit ect or abuse of the client.					
	Based on record re facility's governing adequate direction for 1 of 1 clients, R had sexual contact failure to immediate Administrator and p the clients. The fac alleged staff did no or others during the Direct care failed to allegation of sexual 3. Medical personn of sexual contact 4 investigation the all transport and atten with clients from thi for abuse and negle evaluation or the pr contact with the alle Findings include: On 8/31/11 at 12:20 was identified to ha suspended employ E5, Direct Support	s not met as evidenced by: eview and interview, the body failed to provide for staff to promote the safety 1, who alleged a staff person with the client , due to the ely report this allegation to the blace sufficient safeguards for ility failed to ensure: 1. The t have contact with this client e course of the investigation 2. b immediately report the contact to the Administrator el assessed R1 for evidence . During the course of the eged staff was allowed to d an activity outside the facility s facility 5. The facility policy ect includes any medical otection of clients related to eged perpetrator.					

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		I AND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391
STATEMEN	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	JRVEY TED
		14G238	B. WI	NG			C 3/2011
NAME OF F	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	-	
TIBSTRA	HOUSE				71 EAST 161ST STREET OUTH HOLLAND, IL 60473		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 149	The 2 staff present report the presence the appropriate per bus along with R1, R10, R11, R12, R1 church. E5 attender and E9 and drove t before leaving the f This lack of ensurin alledged sexual abu facility residents po and well being of th an Immediate Jeop E7, Administrator, v Jeopardy on 8/31/1 On 9/6/11 at 2:37pr notified the Immedi R1, per the Physicia 7/28/11, is a 57 yea include Mild Mental Syndrome. 1) The facility policy dated 1/31/08 defin of sexual contact, s coercion, or sexual Sexual abuse inclur fondling, body expo sexual acts with the harassment, etc." T "If an employee obs reason to believe a neglect has occurre immediately report	E4 and E9, DSP's, did not e of E5 on facility grounds to sonnel. E5 drove the facility R2, R3, R4, R5, R6, R7, R9, 3, R14, R15, R16 and E9 to d church with the residents he bus back to the facility acility grounds. Ing a suspended employee for use did not have contact with tentially jeopardized the safety re residents. This resulted in ardy. was notified of the Immediate	W	149			

Facility ID: IL6012009

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/25/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		14G238	B. WI	NG _			3/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
TIBSTRA	HOUSE				271 EAST 161ST STREET SOUTH HOLLAND, IL 60473		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 149	removal of potential removal of accused Review of an Allega dated 8/8/11 comple- notes R1 after retur reported to E5, Direc- touched her private On 8/18/11 E1, Qua (QSP) at 12:24 pm allegation of sexual stated R1 told her E- vaginal area in the r (8/6/11) morning an with his cell phone i E1 said E5 was sus worked on Saturday from 7:00am thru 3 investigation stated heard crying and m known to E6, DSP, 8/6/11. E6 told R1 s manager on Monda On 8/18/11 at 3:15p became aware of th when R1 called her her sister at church conversation R1 be allegations involving the person to talk to QSP, on Monday. V report the allegation	rsons served and facilitate the threat or harm: including employee if appropriate." ation of Abuse/Neglect Report eted by E7, Administrator, ning from work on 8/8/11 act Service Person (DSP) had areas on 8/6/11. alified Service Professional, was asked about the abuse made by R1. E1 E5 touched her breasts and medication room on Saturday d took naked pictures of her n her bedroom at 11:15am. pended on 8/8/11 but had y and Sunday, 8/6/11, 8/7/11, 00pm. E1 stated the R1 at 3:30pm on 8/6/11 was ade the sexual allegation who worked 2nd shift on the needed to talk to her case y. om E3, DSP, stated she he sexual allegation on 8/7/11 at home after she had seen . During their phone gan telling E3 the sexual g E5. E3 told R1 she was not o and she needed to talk to E1, Vhen asked why she did not nimmediately E3 stated	W	149			

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		I AND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	TED
		14G238	B. WI	NG			C 3/2011
NAME OF P	ROVIDER OR SUPPLIER	·			REET ADDRESS, CITY, STATE, ZIP CODE	-	
TIBSTRA	HOUSE				71 EAST 161ST STREET SOUTH HOLLAND, IL 60473		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 149	Continued From pa	ige 9	W	149			
		uld have called (reported the					
	1/31/08 under PRC Procedures, "Any e	y on Abuse and Neglect dated OCEDURES C. General Imployee accused of abuse or ediately suspended with pay the investigation."					
	between a suspend	t address the issue of contact led employee and residents staff actions if a suspended ility grounds.					
	informed surveyor I (DSP), had been te employee who was sexual abuse had b the facility bus with R9, R10, R11, R12 E9, DSP, to church residents and drove before leaving facili E5 had been told he the residents. E7 st on 8/911 he was to second suspension results of an indepen him he is off the sc specifically tell him the residents. E7 w on Abuse and Negl employee's contact "No, it is not that sp have received train suspended employ	5am E7, Administrator, E5, Direct Service Person rminated. E 7 stated E5, an on suspension for alleged been on facility grounds, drove R1, R2, R3, R4, R5, R6, R7, , R13, R14, R15, R16 and , was in the church with the e the bus back to the facility ity grounds. E7 was asked if e is not to have contact with tated in E5's first suspension Id not to come back but on the on 8/12/11 pending the endent investigation he told hedule. E7 stated he didn't he is not to have contact with as asked if the facility policy ect defines a suspended with the residents. He stated, pecific." E7 was asked if staff ing on what to do if a ee comes on facility grounds. ff involved, E4 and E9, he					

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С B. WING 14G238 09/13/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 271 EAST 161ST STREET **TIBSTRA HOUSE** SOUTH HOLLAND, IL 60473 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) W 149 Continued From page 10 W 149 believes received training from E2, Executive Director. Regarding the facility's other staff, E7 stated he discussed in general terms the nature of E5's termination in violating the terms of the suspension but he did not discuss the issue of suspended employee contact with residents or what staff are to do if a suspended employee comes on facility grounds. On 9/1/11 at 8:20am E9, Direct Service Person, who accompanied E5 to church with the residents was interviewed. E9 stated E5 called Sunday (8/21/11) morning. "I told him I was going to church. He volunteered to drive. I said yes since I don't know how to drive the bus. E5 arrived at the facility and stayed on the porch. He did not go into the facility. I rounded up all the residents and we went to church. I was not aware he was suspended. We did not know he was not supposed to have any encounter with the residents. I asked him, are you sure you can be here and he told me he wasn't told he could not have any encounter with the residents." E7 stated E2, Executive Director, called her and said, "I know I didn't tell you but if an an employee is suspended they are not to have any contact with residents." On 9/1/11 at 8:56am the other employee who was present when E5 was on facility grounds, E4, DSP, was interviewed. E4 stated E9 had told her she wanted E5 to drive the bus to church. She said she did not go to church but staved home with a resident who was having a behavior. She said when E5 first arrived both her and E9 with R3 and R13 were on the porch. E5 she said spoke to R3. E4 stated she knew he was suspended but was not aware he was not to have

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		AND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	JRVEY TED
		14G238	B. WIN	IG			C 3/2011
NAME OF F	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
TIBSTRA	HOUSE				71 EAST 161ST STREET OUTH HOLLAND, IL 60473		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	х	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 149	 couldn't be on prem to leave." E7, Administrator, Jeopardy was remot the surveyor confirr facility plan the faci to remove the Immed 1) The facility's Abubeen revised to refl person who is susp allegation of abuse been added to the pemployee shall not served. The susper allowed on the grout facility. The suspen return to the facility allegation and conta they should return to revision is effective administrative team agency policies. 2) The facility's Abubeen revised to refl duty staff should ar been suspended be abuse or neglect, a following has been event that a susper facility, staff on duty him/her to leave an the Program Admin 	e residents. "Had I known he hises I would have asked him was notified the Immediate oved on 9/6/11at 2:37pm.when med through review of the lity took the following actions ediate Jeopardy. Use and Neglect Policy has ect expectations for a staff bended because of an or neglect. The following has policy: "The suspended have contact with any person nded employee shall not be und or inside any agency ided employee shall only if they are cleared of the acted by the administrator that to their schedule duties. This	W	49			

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		I AND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU			(X3) DATE S COMPLE	URVEY ETED
		14G238	B. WI	NG _			C 3/2011
NAME OF P	ROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE	•	
TIBSTRA	HOUSE				271 EAST 161ST STREET SOUTH HOLLAND, IL 60473		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 149	revision is effective administrator will, in administrative team agency policies. 3) The 2 staff on du- were immediately re- Director on 8/22/11 procedures to follow 4) Facility staff have the policy revisions 8/31/11 detailing th facility administrato memo and will main monitoring the issu 5) On 9/1/11 staff re- newly revised Abus have been instructed initial the procedured they have received member of the age agency Training Co- individual basis with purpose of reviewir Policy and ensuring understands the co- procedures of that by 9/15/11. While the Immediat 9/6/11at 2:37pmthe compliance as the	 o be called if necessary. This 9/1/11. The facility n conjunction with the agency n, continue to monitor all uty involved in this incident e-trained by the Executive regarding the proper w in such an event. e been re-trained regarding . Staff received a memo on e upcoming revisions. The r was responsible for the ntain responsibility for e from this point forward. eceived copies of the facilities e and Neglect Policy. Staff ed to review the new policy and e review form to indicate that and understand the policy. A ncy's administrative team or pordinator shall meet on an n each facility employee for the ng the Abuse and Neglect 	W	149			
W 154	opportunity to fully i their plan.		W	154	4		9/20/11

		AND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391	
STATEMENT	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		14G238	B. WI	NG			C 3/2011	
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
TIBSTRA	HOUSE				71 EAST 161ST STREET OUTH HOLLAND, IL 60473			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
W 154	Continued From pa	ige 13	W	154				
	The facility must ha violations are thoro	ave evidence that all alleged ughly investigated.						
	Based on record re failed to complete a allegation of sexual	s not met as evidenced by: eview and interview, the facility a thorough investigation into an l abuse for 1 of 1 clients, R1, staff had touched her						
	Findings include:							
	7/28/11, is a 57 yea	an's Orders Sheet dated ar old female whose diagnoses I Retardation and Down						
	dated 8/8/11 compl notes R1 after retur	ation of Abuse/Neglect Report leted by E7, Administrator, rning from work on 8/8/11 Service Person (DSP) had areas on 8/6/11.						
	(QSP) at 12:24 pm allegation of sexual stated R1 told her E vaginal area in the (8/6/11) morning ar with his cell phone E1 said E5 was sus worked on Saturday from 7:00am thru 3	alified Service Professional was asked about the l abuse made by R1. E1 E5 touched her breasts and medication room on Saturday nd took naked pictures of her in her bedroom at 11:15am. spended on 8/8/11 but had y and Sunday, 8/6/11, 8/7/11, :00pm. E1 stated the ed R1 at 3:30pm on 8/6/11						

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С B. WING 14G238 09/13/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 271 EAST 161ST STREET **TIBSTRA HOUSE** SOUTH HOLLAND, IL 60473 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) W 154 Continued From page 14 W 154 was heard crying and made the sexual allegation known to E6, DSP, who worked 2nd shift on 8/6/11. E6 told R1 she needed to talk to her case manager on Monday. On 8/18/11 at 3:15pm E3, DSP, stated she became aware of the sexual allegation on 8/7/11 when R1 called her at home after she had seen her sister at church. During their phone conversation R1 began telling E3 the sexual allegations involving E5. E3 told R1 she was not the person to talk to and she needed to talk to E1, QSP, on Monday. When asked why she did not report the allegation immediately E3 stated because she did not believe R1. Review of the facility's investigation faxed to the Illinois Department of Public Health dated 8/10/11 includes interviews with R1, R2, Residents, E4, E5, Direct Service Persons, and E1, Qualified Service Professional. The facility's investigation does not include interviews/statements with E3 or E6, the 2 individuals R1 initially told about the sexual allegation. On 8/19/11 at 2:25pm E2, Executive Director, was asked why the facility's investigation did not include interviews/statements by E3 and E6. E2 stated E7, Administrator, did interview them but as to why it was not part of the written investigation stated they focused on getting the information on the allegation into the department. 483.420(d)(3) STAFF TREATMENT OF W 155 W 155 9/20/11 CLIENTS The facility must prevent further potential abuse while the investigation is in progress.

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/25/2012 APPROVED 0938-0391
STATEMENT OF I AND PLAN OF CC		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		14G238	B. WI	NG _			C 3/2011
NAME OF PROV	IDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
TIBSTRA HO	DUSE				271 EAST 161ST STREET SOUTH HOLLAND, IL 60473		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W 155 Co	ontinued From pag	ge 15	W	155	;		
Thi Ba fail clie sta on alle alle cor Fin R1 7/2 inc Syl Re dat not rep tou On (QS alle sta vag (8/4 wit E1 wo frou inv hea	is STANDARD is ased on record re- led to prevent pot- ent, R1, who alleg aff person. The fa- reporting an alleg eged perpetrator egation was made mpletion of the in hdings include: , per the Physicia 28/11, is a 57 yea clude Mild Mental ndrome. eview of an Allega ted 8/8/11 comple- tes R1 after return ported E5, Direct uched her private n 8/18/11 E1, Qua SP) at 12:24 pm egation of sexual ated R1 told her E ginal area in the r 6/11) morning an th his cell phone i said E5 was sus orked on Saturday m 7:00am thru 3: restigation stated ard crying and ma	s not met as evidenced by: eview and interview, the facility tential further abuse of 1 of 1 ged sexual abuse by a facility cility staff were not retrained gation of sexual abuse 2) the continued to work after the e known and prior to the vestigation. an's Orders Sheet dated r old female whose diagnoses Retardation and Down ation of Abuse/Neglect Report eted by E7, Administrator, ning from work on 8/8/11 Service Person (DSP) had					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/25/2012 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		14G238	B. WI	NG			C 3/2011	
NAME OF PI	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
TIBSTRA	HOUSE				71 EAST 161ST STREET SOUTH HOLLAND, IL 60473			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
W 155	manager on Monda On 8/18/11 at 3:15p became aware of th	he needed to talk to her case	W	155				
	seen her sister at cl conversation R1 be allegations involving the person to talk to QSP, on Monday. V	nurch. During their phone gan telling E3 the sexual g E5. E3 told R1 she was not and she needed to talk to E1, When asked why she did not immediately E3 stated						
W 331	8/18/11 at 12:24pm re-inserviced on rep other DSP's, E8, E9	-	W :	331			9/20/11	
		ovide clients with nursing nce with their needs.						
	Based on record re failed to ensure 1 of	s not met as evidenced by: view and interview, the facility f 1 individuals, R1, who had touched her sexually is al personnel.						
	Findings include:							
	7/28/11, is a 57 yea	an's Orders Sheet dated r old female whose diagnoses Retardation and Down						

		I AND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		14G238	B. WI	IG			C 3/2011
NAME OF P	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
TIBSTRA	HOUSE				71 EAST 161ST STREET OUTH HOLLAND, IL 60473		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 331	Continued From pa Syndrome.	ge 17	W	331			
	1/31/08 defines Sex sexual contact, sex coercion, or sexual Sexual abuse inclue fondling, body expo sexual acts with the harassment, etc." T states, "Obtain cop that pertain to the ir statements, medica	ted Abuse and Neglect dated kual Abuse as, "Any act of ual penetration, sexual exploitation of an individual. des, but is not limited to: bsure, rape, engagement in e persons served, sexual The General Procedure section ies of documents or records incident, including written al reports, individual records, iny applicable evidence."					
	dated 8/8/11 compl notes R1 after retur reported E5, Direct	ation of Abuse/Neglect Report eted by E7, Administrator, ming from work on 8/8/11 Service Person (DSP) had areas on 8/6/11 including her l area.					
		1's file does not contain any been seen medically after the known.					
W9999	on 8/19/11 at 10:45	Qualified Service Professional, am when asked if R1 had ly stated, "I don't believe so." IONS	W99	999			
	LICENSURE FIND	INGS					
	350.620a) 350.1220e) 350.1220j) 350.3240a) 350.3240b)						

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		I AND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU			(X3) DATE SURVEY COMPLETED C	
		14G238	B. WI	NG _			3/2011
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
TIBSTRA	HOUSE				271 EAST 161ST STREET SOUTH HOLLAND, IL 60473		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
W9999	Continued From pa 350.3240e)	ge 18	W9	999	9		
	Section 350.620 Re	esident Care Policies					
	procedures governi facility which shall b involvement of the a shall be available to public. These writte	have written policies and ing all services provided by the be formulated with the administrator. The policies b the staff, residents and the en policies shall be followed in y and shall be reviewed at					
	Section 350.1220 P	hysician Services					
		Il be seen by their physician as to assure adequate health					
	of any accident, inju condition that threa welfare of a residen the presence of inci	notify the resident's physician ury, or change in a resident's tens the health, safety or nt, including, but not limited to, ipient or manifest decubitus oss or gain of five percent or d of 30 days.					
	Section 350.3240 A	buse and Neglect					
		ee, administrator, employee or nall not abuse or neglect a 2-107 of the Act)					
	aware of abuse or r immediately report	ee or agent who becomes neglect of a resident shall the matter to the facility tion 3-610 of the Act)					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/25/2012 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		14G238	B. WI	NG _		C 09/13/2011	
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
TIBSTRA	A HOUSE				271 EAST 161ST STREET SOUTH HOLLAND, IL 60473		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W9999	investigation of a re- resident indicates, I that an employee o perpetrator of the a immediately be bar with residents of the of any further inves disciplinary action a 3-611 of the Act) These Regulations by: Based on record re- facility's governing adequate direction for 1 of 1 clients, R had sexual contact failed to ensure: 1. Direct care staff allegation of sexual 2. The alleged perp with this client or ot investigation 3. Medical personn of sexual contact 4. The facility policy includes any medic of clients related to perpetrator. Findings include: R1, per the Physicia 7/28/11, is a 57 year	ge 19 petrator of abuse. When an port of suspected abuse of a based upon credible evidence, f a long-term care facility is the buse, that employee shall red from any further contact e facility, pending the outcome tigation, prosecution or gainst the employee. (Section were not met as evidenced view and interview, the body failed to provide for staff to promote the safety 1, who alleged a staff person with the client. The facility immediately reported the contact to the Administrator etrator did not have contact hers during the course of the el assessed R1 for evidence v for abuse and neglect al evaluation or the protection contact with the alleged	W9	999			

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		I AND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		14G238	B. WI	NG			C 3/2011
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
TIBSTRA	HOUSE				71 EAST 161ST STREET SOUTH HOLLAND, IL 60473		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W9999	Continued From pa	ge 20	W9	999			
	dated 1/31/08 defin of sexual contact, s coercion, or sexual Sexual abuse includ fondling, body expo sexual acts with the harassment, etc." T "If an employee obs reason to believe at has occurred he/sh report the allegation or designee, who sl the persons served potential threat or h accused employee Review of an Allega dated 8/8/11 compli- notes R1 after retur reported E5, Direct touched her private On 8/18/11 E1, Qua (QSP) at 12:24 pm allegation of sexual stated R1 told her E vaginal area in the (8/6/11) morning ar with his cell phone in E1 said E5 was sus worked on Sunday, 3:00pm. E1 stated f 3:30pm on 8/6/11 w sexual allegation kr	ation of Abuse/Neglect Report eted by E7, Administrator, rning from work on 8/8/11 Service Person (DSP) had areas on 8/6/11. alified Service Professional was asked about the abuse made by R1. E1 E5 touched her breasts and medication room on Saturday hd took naked pictures of her in her bedroom at 11:15am. spended on 8/8/11 but had 8/7/11, from 7:00am thru the investigation stated R1 at vas heard crying and made the nown to E6, DSP, who worked E6 told R1 she needed to talk					

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		AND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391
STATEMEN	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		14G238	B. WI	NG			C 3/2011
NAME OF F	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
TIBSTR	HOUSE				71 EAST 161ST STREET SOUTH HOLLAND, IL 60473		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W9999	Continued From pa	ige 21	W9	999			
	On 8/18/11 at 3:15p became aware of the when R1 called her her sister at church conversation R1 be allegations involving the person to talk to QSP, on Monday. We report the allegation because she did not E1 in her interview E7 stated they show allegation). 2) The facility policy 1/31/08 under PRO Procedures, "Any eneglect will be imm until completion of the The policy does not between a suspend nor does it address employee is on facility formed surveyor for terminated. E 7 state on suspension for a on facility grounds, R2, R3, R4, R5, R6 R13, R14, R15, R1 in the church with the back to the facility to E7 was asked whet	om E3, DSP, stated she he sexual allegation on 8/7/11 at home after she had seen . During their phone egan telling E3 the sexual g E5. E3 told R1 she was not o and she needed to talk to E1, When asked why she did not n immediately E3 stated ot believe R1. on 8/18/11 stated both E3 and uld have called (reported the y on Abuse and Neglect dated OCEDURES C. General employee accused of abuse or ediately suspended with pay the investigation." t address the issue of contact led employee and residents staff actions if a suspended ility grounds. 5am E7, Administrator,					

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С B. WING 14G238 09/13/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 271 EAST 161ST STREET **TIBSTRA HOUSE** SOUTH HOLLAND, IL 60473 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) W9999 Continued From page 22 W9999 E5's first suspension on 8/911 he was told not to come back but on the second suspension on 8/12/11 pending the results of an independent investigation he told him he is off the schedule. E7 stated he did not specifically tell E5 he is not to have contact with the residents. E7 was asked whether the facility policy on Abuse and Neglect defines a suspended employee's contact with the residents. He stated, "No, it is not that specific." E7 was asked whether staff have received training on what to do if a suspended employee comes on facility grounds. E7 stated the two staff involved, E4 and E9, he believes received training from E2, Executive Director. Regarding the facility's other staff, E7 stated he discussed in general terms the nature of E5's termination in violating the terms of the suspension but he did not discuss the issue of suspended employee contact with residents or what staff are to do if a suspended employee comes on facility grounds. On 9/1/11 at 8:20am, E9, DSP, who accompanied E5 to church with the residents was interviewed. E9 stated E5 called Sunday (8/21/11) morning. "I told him I was going to church. He volunteered to drive. I said ves since I don't know how to drive the bus. E5 arrived at the facility and stayed on the porch. He did not go into the facility. I rounded up all the residents and we went to church. I was not aware he was suspended. We did not know he was not supposed to have any encounter with the residents. I asked him, are you sure you can be here and he told me he wasn't told he could not have any encounter with the residents." E7 stated E2, Executive Director, called her and said, 'I know I didn't tell you but if an an employee is suspended they are not to have any contact with

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/25/2012 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		14G238	B. WII	NG			C 3/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	-	
TIBSTRA	HOUSE				71 EAST 161ST STREET SOUTH HOLLAND, IL 60473		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W9999	Continued From pa residents.'"	ge 23	W9	999			
	was present when I DSP, was interview she wanted E5 to d said she did not go with a resident who said when E5 first a R3 and R13 were o spoke to R3. E4 sta suspended but was any contact with the	m the other employee who E5 was on facility grounds, E4, red. E4 stated E9 had told her rive the bus to church. She to church but stayed home was having a behavior. She arrived both her and E9 with in the porch. E5 she said ated she knew he was not aware he was not to have e residents. "Had I known he hises I would have asked him					
	dated 1/31/08 defin of sexual contact, s coercion, or sexual Sexual abuse inclue fondling, body expo sexual acts with the harassment, etc." T states, "Obtain copi that pertain to the ir statements, medica photographs, and a The policy does not action is to be taken abuse occurs. Review of an Allega dated 8/8/11 compl notes R1 after retur reported E5, Direct	v titled Abuse and Neglect es Sexual Abuse as, "Any act exual penetration, sexual exploitation of an individual. des, but is not limited to: sure, rape, engagement in e persons served, sexual The General Procedure section ies of documents or records noident, including written al reports, individual records, ny applicable evidence." t define what specific medical n when an allegation of sexual ation of Abuse/Neglect Report eted by E7, Administrator, ming from work on 8/8/11 Service Person (DSP) had areas on 8/6/11 including her					

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		I AND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU			(X3) DATE SURVEY COMPLETED C	
		14G238	B. WII	NG			3/2011
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
TIBSTRA	HOUSE				271 EAST 161ST STREET SOUTH HOLLAND, IL 60473		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W9999	Continued From pa	-	W9	99	9		
	breasts and vagina Record review of R information R1 had person (nurse or ph Interview with E1, C on 8/19/11 at 10:45 had been seen med so." Interview with E2, E at 2:25pm acknowle abuse/neglect does	l area. 1's file does not contain any been evaluated by a medical					

Facility ID: IL6012009