STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145856	A. BUILDING _____ B. WING _____	C 02/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL FAITH PAVILION	**3500 SOUTH GILES AVENUE CHICAGO, IL 60653**

(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	FINAL OBSERVATIONS LICENSURE VIOLATIONS Section 300.690 a) Section 300.690 b) Section 300.690 c) Section 300.1210 b) Section 300.1210 d)6) Section 300.3240a) Section 300.3240b) Section 300.3240d) Section 300.3240 f) Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. Section 300.1210 General Requirements for	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145856	A. BUILDING _____ B. WING _____	C 02/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL FAITH PAVILION	**3500 SOUTH GILES AVENUE CHICAGO, IL 60653**

(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 Nursing and Personal Care b) The facility shall 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 resident care plan. 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: d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 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 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act) d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145856	A. BUILDING _____ B. WING _____	C 02/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL FAITH PAVILION	**3500 SOUTH GILES AVENUE CHICAGO, IL 60653**

(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 shall also report the matter to the Department. (Section 3-610 of the Act) f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act) THESE REGULATIONS WERE NOT MET AS EVIDENCED BY: Based on interviews, observations, and record review the facility failed to protect three residents (R3,R6,R9) from being physically abused involving 6 of 14 residents(R3,R6,R7,R8,R9,R17) reviewed for abuse and neglect out of a total sample of 16 and failed to prevent 1 resident (R1) from sexual abuse involving 2 of 14 residents (R1,R2) reviewed for abuse in a sample of 16. These failures resulted in physical harm to R3,R6, R9 and sexual abuse to R1.These failures has the potential to affect all residents in the facility. The facility was aware of R9's diagnosis of Mental Retardation and history of abuse from R17 and R8. Facility staff failed to protect R9 from being the victim of physical abuse and failed to implement interventions to protect R9 from further abuse from R17 and R8.	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145856	A. BUILDING _____ B. WING _____	C 02/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL FAITH PAVILION	**3500 SOUTH GILES AVENUE CHICAGO, IL 60653**

(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 50	F9999		

Findings Include:

(1) -R9 record denotes in part diagnosis of Mental Retardation, Paranoid Schizophrenia. R9 was observed on 2/2/2012- 12:00pm with poor grooming/hygiene. R9 stated," R17 hit me on head, busted my nose, knocked my teeth out, and punched me. R17 use to be my boyfriend. Also, R8 knocked me down, and kicked me in my eye. I fought back, and told E5 (PRSC/Psychiatric Rehabilitation Service Coordinator). E5(PRSC) told me to just stay away from them."

R17 record denotes in part diagnosis of Schizo-Affective Disorder. R17 was observed on 2/2/2012-12:20pm with pressured speech; poor hygiene and poor judgement. R17 stated," R9 grabbed my cigarette and I hit R9 in the mouth. Three times I hit R9, another time R9 was trying to wrestle me, I punched her in the nose, and then I hit R9 in the head and spit on her because R9 was throwing paper wrappers at me. I have been asking E5(PRSC) to move me to another floor or nursing home. R9 said, no. I can not walk away when I am in the moment. I have to hit R9."

The facility incident reports dated 10/18/11 in part denotes" above resident fighting a female peer. The documentation depicts R9 sustained a cut on bottom lip and gums." Again, the facility nursing documentation dated 1/24/12 depicts," Resident (referring to R17) reported an altercation with peer (referring to R9). The resident/resident altercation form of 1/22/2012- denotes in part; R17 struck R9 in the arm repeatedly because R9

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145856	A. BUILDING _____ B. WING _____	C 02/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL FAITH PAVILION	**3500 SOUTH GILES AVENUE CHICAGO, IL 60653**

(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 51 was trying to hold a conversation with R17." R8 record denotes in part diagnosis of Bipolar Disorder; SchizoAffective Disorder. R8 on 2/2/12 -2:30pm was observed irritable; disorganized thinking and poor grooming. R8 stated,"I hit her (referencing R9) , she was sexually inappropriate, looked at me, not touched me. I never told anyone, I hit her in eye, stomped her. On my side of the hallway, my floor and I cursed her, I threatened her real good." The facility nurses notes dated 12/28/2011 at 10;54pm depicts in part," received endorsement from morning that resident was involved in a physical aggression with a female resident." On 2/2/12, E5 (PRSC) queried regarding the above physical abuse allegations by E9, and confirmation by R17 and R8 stated, " I was made aware by notes, and by E2 (PRSD/Asst Administrator), I talked to R9 about staying away from the resident's. I did not do a plan for safety for R9. The nurses gave PRN meds to R17. Also, I talked to ..... (local)nursing home and R17 will be transferred on Monday (referencing 2/6/12). I also monitor R9 every 2 hours." E9 (nurse of R17 and R8) interviewed 2/6/12-2:30pm regarding behaviors of R17 and R8. E9 (nurse) in part stated," R17 is unpredictable, will hit resident's and staff, very irrational on a daily basis. R8 is unpredictable, extremely." On 2/1/12 at 9:32am during initial tour of the facility along with E3 (Director of Nurses, DON), R7 was in the hallway screaming at R21. R7 was	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145856	A. BUILDING _____ B. WING _____	C 02/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL FAITH PAVILION	**3500 SOUTH GILES AVENUE CHICAGO, IL 60653**

(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 52	F9999		

also stating " I want to get out of this fu ..... place. R7 was admitted to the facility on 5/11/11 with a diagnosis of bipolar.

The facility ' s Accident/Incident Report dated 1/9/12 involving R7 and R6 documents that R7 struck R6 in the face and R6 struck R7 back. The facility ' s Accident/Incident Report dated 1/9/12 involving R7 and R3 documents that R7 climbed into R3 ' s bed and pulled R3 ' s hair and scratched R3 on the forehead.

The facility did not provide an investigation into these incidents. As of 2/1/12, R3 and R7 both continued to reside in the same room.

On 2/2/12pm at 1:30pm, in the conference room, R3 stated that R3 was asleep and R7 pulled R3 ' s hair and scratched R3 in the face. R3 stated that R3 was mad and afraid once this had occurred. R3 stated that R3 reported the incident to E5 (PRSC Psychiatric Rehabilitation Service Coordinator/PRSD Psych Rehab Service Director).

On 2/2/12pm at 1:35pm, R6 stated that R6 can not recall the incident.

On 2/2/12pm at 1:45pm, R7 initially denied the incident, but then confirmed the incident with R3 had in fact occurred.

On 2/2/12 at 1:46pm, E9 (LPN) stated that E9 heard R3 screaming and entered R3 ' s room. E9 stated that E9 noted 3 scratches on R3 ' s forehead. E9 stated that R3 informed E9 that R7 had hit and scratched R3. E9 stated that E9 notified E5 and the R7 ' s physician. E9 stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145856	A. BUILDING _____ B. WING _____	C 02/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL FAITH PAVILION	**3500 SOUTH GILES AVENUE CHICAGO, IL 60653**

(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 53	F9999		

that E9 completed an incident report, but does not remember being interview by E3 (Director of Nurses) or E4 (Administrator at time of incident).

On 2/2/12 at 2:30pm, E5 stated that E5 was informed by staff about the incidents between R3, R6 and R7. E5 stated that R7 informed E5 that R7 attacked R3 because R7 had awakened from a bad dream and thought R3 was after her. E5 stated that both residents remain in the same room.

On 2/2/12 at 2:40pm, E3 stated no investigation into the incidents occurred because "there's no way anyone could have seen it." The facility did not present a thorough investigation into the incidents.

2. Based on interviews, observations, and record review the facility failed to implement its own policies and procedures that prohibit abuse involving 8 of 14 residents(R1,R2,R3,R6,R7,R8,R9,R17) reviewed for abuse of a total sample of 16. These failures resulted in R3,R6 and R9 being physically abused and R1 being sexually abused. These failures has the potential to affect all residents in the facility.

The facility was aware of R2 ' s coercing R1 into having sex and failed to implement interventions to protect R1 and other female residents.

Findings include:

On 2/1/12 at 9:00am, during the entrance conference, E4 (Administrator on date of entry) was asked to provide all incidents/accidents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145856	A. BUILDING _____ B. WING _____	C 02/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL FAITH PAVILION	**3500 SOUTH GILES AVENUE CHICAGO, IL 60653**

(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 54	F9999		

reportable and non-reportable, abuse allegations, grievances and concerns from Nov 2011 - Feb 2012. During initial tour along with E3 (Director of Nurses), at 9:25am, R1 was sitting at a table in the first floor dining room. E3 stated that R1 had been moved to the first floor some months ago because R1 has a history of seizures and mental illness. The Physician ' s Order Sheet (POS) for R1 documents the following diagnoses: mental retardation, seizure disorder, convulsions, and hypertension.

On 2/1/12 at 10:30am, review of the facility ' s incidents/accidents, abuse allegations, grievances and concerns revealed no occurrence between R1 and R2.

On 2/1/12 10:47am along with Z2 (Investigator, Illinois State Police), R1 stated " some man on the floor be asking me for things. " R1 further stated that man touched her in private places. R1 goes on to state that she does not have a boyfriend in the facility. R1 then stated that a man who resides on the second floor asks R1 for sex. R1 stated that the man forced R1 to have sex and then was moved to the third floor. R1 stated " I told the man in the office and he said if people mess with me again, I should knock them out. " R1 could not give a clear account as to whether R1 had gone to the hospital or not, but indicated that R1 received a physical assessment from someone. R1 stated " he has forced himself on me once or twice. " After pondering the date, R1 indicated the incident occurred on Saturday (1/30/12) evening. R1 stated there was some sexual penetration and that R1 wanted the man to stop. R1 stated he wants me to suck his d ...(referring to the male genitalia). R1 added "

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145856	A. BUILDING _____ B. WING _____	C 02/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL FAITH PAVILION	**3500 SOUTH GILES AVENUE CHICAGO, IL 60653**

(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 55	F9999		

he does that everyday. " R1 then stated that R1 does not want to do that, and have informed staff that he has forced himself onto R1 sexually. R1 stated that the facility had moved the man to a different room because of the incident on 1/30/12. R1 stated that R1 experienced bleeding when the man forced himself on her. R1 then added that the man asks R1 if R1 wants to have a baby. R1 also stated " he wants money, and wants me to buy him cigarettes. " When asked how all of this makes you feel, R1 replied " I don ' t like it, he asks me for sex. " R1 identified the man as " the colored man " , but could not recall his name. R1 stated that R1 can identify the man. R1 stated that R1 had told E3 (Director of Nursing) and E4 (Administrator-at time of entry into the facility) of the incident. R1 went to the 3rd floor to identify the man. As R1 entered the elevator, so did E4. R1 began pointing at E4 stating ' I told you, remember I told you. " R1 walked around the 3rd floor and did not locate the man. At 11:20am, E12 (Certified Nursing Assistant, C.N.A) stated someone was transferred up here a couple of days ago, but was sent back to the second floor. E12 identified the person as R2. R1 walked on the second floor and at 11:35AM, as R1 passed the nursing station, E11 (Registered Nurse, RN) stated R2 is at a day program and he ' s the one you ' re looking for. When asked how E11 knew who we were looking for, E11 stated because of an incident that happened with R1 and R2. E11 then stated " if you ' re going to ask me about the incident, I don ' t know anything. " E11 further stated that R2 was transferred to the unit under E11 ' s care after the incident, but E11 did not get details as to why R2 had been transferred. At 4:00pm, R1 identified R2 as the man who had forced sex upon her.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145856	A. BUILDING _____ B. WING _____	C 02/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL FAITH PAVILION	**3500 SOUTH GILES AVENUE CHICAGO, IL 60653**

(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 56	F9999		

On 2/1/12 at 12:10pm (location-conference room) along with Z2 and Z3 (Special Agent, Illinois State Police), E13 (Psychiatric Rehabilitation Service Coordinator, PRSC) stated that R2 was moved to the third floor on because of inappropriateness with R1, but was transferred back to the second floor Tuesday. E13 further stated that R1 and R2 had oral sex and R1 didn ' t want to give R2 oral sex. E13 stated that R1 reported the incident to E10 (Activity Aide) and E10 reported the incident to E13. E13 then stated that E13 reported the incident to E2 (PRSD/Assistant Administrator) and that E2 communicated with E4 that night. E13 stated that E14 (Case manager) had also spoken to E4. E13 added that E4 interviewed E13 on 1/31/12 about the incident but did not ask E13 to write a statement. E13 also stated that the facility ' s policy for sexual abuse is for the nurse on duty to contact the physician immediately. E13 stated that the nurse on duty when R1 notified staff of R2 ' s sexual inappropriateness was E15 (Licensed Practical Nurse, LPN).

On 2/1/12 in the facility ' s conference room along with Z2 and Z3, E2 stated that R2 was transferred on Monday night (1/30/12) and an investigation into the allegation related to R1 was started. E2 stated that E2 spoke with R2 on 1/31/12. E2 stated that R2 explained how R2 entered R1 ' s room and sat on the bed and lowered R2 ' s pants, then R1 began to perform oral sex on R2. E2 stated the incident occurred on Saturday (1/28/12) and R1 informed staff of the incident on the evening of 1/30/12. E2 stated that the facility ' s policy for abuse allegations is to report the incident to the facility ' s Administrator, and to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145856	A. BUILDING _____ B. WING _____	C 02/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL FAITH PAVILION	**3500 SOUTH GILES AVENUE CHICAGO, IL 60653**

(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 57	F9999		

ensure the residents do not come in contact with each other. E2 then added that the facility must report the incident to Illinois Department of Public Health within 24 hours of finding out. E2 further indicated that the facility ' s policy is to monitor the residents 1:1, send the victim to the hospital for evaluation, and contact the facility ' s psychiatrist. E2 stated that E2 does not believe R1 was sent to the hospital for evaluation. E2 stated that E4 received statements on 1/31/12 regarding the incident. E2 added that it is the Administrator ' s decision whether or not to call the local authorities. E2 stated that R1 informed E2 that R1 and R2 had previously engaged in consensual sexual intercourse. E2 stated however, R1 had told E14 that R1 had sex with R2 but did not want to. E2 stated that R1 is able to verbalize consent.

On 2/1/12 12:20pm (location-conference room) along with Z2 and Z3, E14 stated that the facility ' s policy for allegations of sexual abuse is to immediately report it to the supervisor. E14 stated that E10 and E13 informed E14 of the incident between R1 and R2, and E14 informed E2 and E4. E14 stated that E14 interviewed R1 and that R2 wanted to have sexual intercourse, but R1 did not. E14 added that R1 stated R2 entered R1 ' s room and asked her to go into the bathroom and to perform oral sex. E14 further added that R1 informed R2 that R1 didn ' t want to have oral sex, however, R2 dropped his pants and R1 performed oral sex. E14 stated that E2 and E4 were not in the building when staff found out about the incident, but E14 wrote a statement and slid it under their office doors. E14 however stated that E14 spoke on the phone with E2 and E4 on 1/31/12, and that E2 and E4 contacted E14 the next day.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145856	A. BUILDING _____ B. WING _____	C 02/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL FAITH PAVILION	**3500 SOUTH GILES AVENUE CHICAGO, IL 60653**

(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 58 On 2/1/12 12:30pm (location-conference room) along with Z2 and Z3, E3 (Director of Nurses DON) stated that the facility ' s policy for resident to resident abuse is to separate the two residents. E3 also stated the facility ' s policy is to call the physician right away and to send the aggressor out. E3 added that the initial report should be faxed to IDPH within 24 hours and the final investigation within 5 days. E3 stated that the nurse must document the incident in the nurse ' s notes and the facility keeps the documentation in their computer system. E3 further added that it is the nurse ' s responsibility to notify the DON and Administrator and to notify the physician of the resident ' s change in condition. E3 goes on to state that if the incident is sexual in nature, the nurse must send the victim to the emergency room and call the police. E3 stated however, R1 was not sent to the emergency room. E3 stated that R1 said R1 felt pressured into having sex. E3 stated that E3 spoke with R1 ' s sister and that R1 ' s physician has not been notified of the incident. E3 also stated that the fact that R1 stated she was pressured into having sex depends on whether or not she's had a history of sexual intercourse with the accused. E3 stated that E3 had spoken with R2 and R2 indicated that R2 made R1 perform oral sex. E3 stated that E3 went and drove the family member of R1 to the facility to clarify what R1 was communicating to the facility. E3 stated that R1 informed E3 that R1 and R2 had entered the bathroom, then went to R1 ' s bed, sat down, turned on the television, and the act of oral sex was performed. E3 added that R1 didn ' t care for oral sex. E3 stated that R2 said, in the presence of R1 ' s family member, that R1 had provided oral sex. E3 stated that E3	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145856	A. BUILDING _____ B. WING _____	C 02/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL FAITH PAVILION	**3500 SOUTH GILES AVENUE CHICAGO, IL 60653**

(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 59	F9999		

never spoke with R2 about the incident in a private environment.

On 2/1/12 at 1:05pm (location-conference room) along with Z2 and Z3, E4 stated the reason the allegation/incident was not provided to the survey team is because it was an internal investigation. E4 stated " it was not an abuse investigation. " E4 stated that E4 was informed about the incident between R1 and R2. E4 also stated that E4 had spoken with R1 on 1/31/12. E4 goes on to state that the facility ' s policy for nonconsensual sex is to notify the physician and local authorities at the time of the incident and report it to the state surveying agency within 24 hours, and this did not occur. E4 stated that E4 received a call on the night of 1/31/12 from E14 about the issue with R1 and R2. E4 stated R1 had indicated that R1 did not like oral sex and did not want to have oral sex. E4 stated that E4 does not normally get phone calls when resident have sexual intercourse. E4 stated that R2 was moved on 1/30/12. E4 stated that the facility did not notify the physician, policy or state surveying agency of the nonconsensual sex between R1 and R2. E4 presented four statements that E4 indicated was a part of an internal investigation. However, these statements do not appear to have been part of a complete investigation of alleged sexual abuse.

On 2/1/12 at 1:25pm along with Z2 and Z3 (location conference room), E10 stated that on 1/30/12, R1 informed E10 that on Saturday a male resident kept coming into R1 ' s room wanting R1 to do things. E10 stated that R1 indicated that R1 and R2 had sex, but R1 did not want to. E10 stated " R1 told me that R1 and R2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145856	A. BUILDING _____ B. WING _____	C 02/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL FAITH PAVILION	**3500 SOUTH GILES AVENUE CHICAGO, IL 60653**

(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 60	F9999		

had vaginal sex and then oral. E10 stated that R1 did not want to do that (oral sex) but R2 was pushing on R1 ' s head (E10 demonstrated) to make her do it (oral sex). E10 stated that E10 informed E3 and E13 about the vaginal and oral sex and that R1 did not want this to occur. E10 stated that no one asked E10 to provide a written statement.

On 2/1/12 at 2:00pm along with Z2 and Z3 (location-conference room), E15 stated that R2 is on the second floor (unlocked unit). E15 stated that E14 had informed E15 about nonconsensual sex between R1 and R2 and was trying to report it. E15 stated that E15 called E2 and E3. E15 stated that E15 spoke with E4 and informed E4 that E15 was going to call the police. According to E15, E4 stated " no " and that E3 and E4 was going to come into the facility the next day and investigate. E15 stated that E3 however, informed E15 that E3 would come into the facility that evening. E15 stated however, neither E3 nor E4 entered the facility that day. E15 stated that E15 checked R1 ' s vital signs and performed an head to toe physical assessment which include inspection of the vaginal area, but did not document the assessment. E15 stated the facility ' s policy for nonconsensual sex is to inform E4. E15 stated that E15 called E16 (Licensed Practical Nurse, LPN) and informed E16 that R2 would be transferred to E16 ' s unit. E15 stated that E15 paged the physician at 8:45pm but did not receive a return call. E15 stated that E15 did not try to reach the physician again, but reported the incident to E9 (LPN) during shift change.

On 2/1/12 at 2:57pm (location-conference room) along with Z2 and Z3, R2 stated " they (referring

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145856	A. BUILDING _____ B. WING _____	C 02/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL FAITH PAVILION	**3500 SOUTH GILES AVENUE CHICAGO, IL 60653**

(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 61	F9999		

to staff) said it was ok to have sex in the building. When asked about R1, R2 stated " I don ' t know who that is. " R2 stated " they had me in the office the other day. I didn ' t do anything with her. " Z2 escorted R2 to the dining room, R1 was sitting at the other end of the dining room. R2 looked across the room and stated " I didn ' t do anything with her. " Once back in the conference room, R2 stated " we had oral sex. " R2 stated that R2 had entered R1 ' s room and R1 had given R2 a quarter. R2 stated that R2 took R2 ' s pants down and " she went down on me (referring to oral sex). " When asked if R1 had given consent to oral sex, R2 stated " she did it before. " R2 stated that R2 has spoken with E4 in relation to the incident. R2 denies having vaginal sex with R1 and states the two of them has had oral sex two times. R2 stated " I knew something was strange when I tried to kiss her, because she wouldn ' t kiss back. R2 then stated that a couple of days later R2 met with E2 and E4, and E4 stated " just stay off the first floor, we got you out of it this time. " R2 stated they then changed his room (to a locked unit) and informed R2 that he could have gotten into big trouble, but R2 was moved back into the same room (on an unlocked unit) the next day. R2 stated that in R2 ' s presence, R1 informed R1 ' s family member that R1 did not like oral sex. R2 stated E16 said " you can have sex in the room with the curtains pulled back. " R2 now stated he didn ' t ask R1 if she wanted to have sex, and he just assumed she wanted to because she had done it before. R2 stated he just stood in from of R1 and pulled his pants down and she " just did it " (referring to oral sex). R2 goes on to state that E16 stated " you ' re lucky, you could have been in jail. " R2 stated he had also spoken with E13,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145856	A. BUILDING _____ B. WING _____	C 02/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL FAITH PAVILION	**3500 SOUTH GILES AVENUE CHICAGO, IL 60653**

(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 62	F9999		

and E14.

On 2/1/12 at 3:57pm (location-conference room), E16 stated that E14 informed E16 that R2 would be transferred off of her unit. E16 stated that E16 asked R2 what had happened and R2 responded that R2 had gotten a couple of girls to have sex. E16 then stated that later that night, R2 stated he had oral sex. E16 stated that E16 only documented that R2 was transferred to the third. E16 stated that E16 did not get details as to why E16 was transferring a resident that was under E16 ' s care, nor provide the receiving nurse with a report as to why the resident was being transferred.

On 2/2/12 at 3:20pm (location-conference room), E15 stated " I was nervous yesterday and not totally forthcoming. " E15 stated that E15 had been pressured on the day the survey team entered the facility. E15 goes on to state that E15 did not document the incident between R1 and R2 because E4 instructed E15 not to. E15 stated that after E4 informed E15 not to call the authorities or document, E3 stated to do what E4 said. E15 further stated that E16 stated that E16 would only document that R2 was transferred because E4 had informed E16 not to document the incident. E15 ended the conversation by saying E15 did not page the physician a second time because E4 instructed E15 not to.

The facility did not follow their abuse policy and procedure which documents the following:

Illinois Council on Long Term Care. Abuse Prevention Program.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145856	A. BUILDING _____ B. WING _____	C 02/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL FAITH PAVILION	**3500 SOUTH GILES AVENUE CHICAGO, IL 60653**

(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 63 Policy-purpose is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, neglect or abuse of our residents. This will be done by: - immediately protecting residents involved in identified reports of possible abuse. -implementing systems to investigate all reports and allegations of mistreatment promptly and aggressively, and making the necessary changes to prevent future occurrences; and filing accurate and timely investigative reports . Supervisors shall immediately inform the administrator or designee of all reports of potential mistreatment. Upon learning of the report, the administrator or designee shall initiate an incident investigation. V). Protection of Residents The facility will take steps to prevent mistreatment while the investigation is underway. Residents who allegedly mistreat another resident will be removed from contact with that resident during the course of the investigation. The accused resident ' s condition shall be immediately evaluated to determine the most suitable therapy, care approaches, and placement, considering his or her safety, as well as the safety of other residents and employees of the facility. Accused individuals not employed by the facility will be denied unsupervised access to the resident during the course of the investigation. Final Investigation Report. The investigator will report the conclusions of the investigation in writing to the administrator or designee within five working days of the reported incident. The final investigation report shall contain the following: -Name, age, diagnosis and mental status of the	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145856	A. BUILDING _____ B. WING _____	C 02/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL FAITH PAVILION	**3500 SOUTH GILES AVENUE CHICAGO, IL 60653**

(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 64 resident allegedly abused or neglected -The original allegation -Facts determined during the process of the investigation, review of medical record and interview of witnesses -Conclusion of the investigation based on known facts -If there is a police report, attach the police report -Attach a summary of all interviews conducted, with names addresses, phone numbers and willingness to testify of all witnesses. The administrator or designee will review the report. The administrator or designee is then responsible for forwarding a final written report of the results of the investigation and of any corrective action taken to the Department of Public Health within five working days of the reported incident. External Reporting of Potential Abuse 1). Initial Reporting of allegation. Within 24 hours after the occurrence, a written report shall be sent to the Department of Public Health. Possible Sexual Abuse Definition: Sexual abuse includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault -Contact the police The facility ' s Change in Resident ' s Condition policy documents the following: It is the policy of All Faith Pavilion to notify the resident ' s physician of all changes in resident ' s condition. All reports and documentation of a change in condition must include the following: -Name of resident -Room number	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145856	A. BUILDING _____ B. WING _____	C 02/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL FAITH PAVILION	**3500 SOUTH GILES AVENUE CHICAGO, IL 60653**

(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 65 -Type of change noted -vital signs --Any psychosocial/nursing intervention initiated -Notify nurse manager -Call physician -Call the resident ' s responsible party The resident ' s physician/hospital/E.R./911 must be notified. (A)	F9999		