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	145856	A. BUILDING ______ B. WING ______	C 03/09/2012

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

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F 323	Continued From page 17 20). An additional staff member will be assigned on the unit to complete the monitoring for residents on the unit. 21). The Assistance Director of Nursing will be assigned to check the monitoring log daily. 22). Quarterly, all residents assess with poor cognitive ability will be reviewed. 23). Quarterly, all residents assess with poor cognitive ability will safety aware and determine if continuous monitoring is needed. 24). The Assistant Director of Nursing will monitor the surveillance program quarterly to ensure accuracy.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.690a) 300.690b) 300.690c) 300.695b)3) 300.695c)5) 300.1040c) 300.1210a) 300.1210b) 300.3240a) 300.3240d) 300.3240f) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and	F9999		

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F9999	Continued From page 18 representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. 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 300.695 Contacting Local Law Enforcement b) The facility shall immediately contact local law	F9999		

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F9999	Continued From page 19 enforcement authorities (e.g., telephoning 911 where available) in the following situations: 3) Sexual abuse of a resident by a staff member, another resident, or a visitor. c) The facility shall develop and implement a policy concerning local law enforcement notification, including: 5) Facility investigation of the situation. Section 300.1040 Care and Treatment of Sexual Assault Survivors c) The facility shall take all reasonable steps to preserve evidence of the alleged sexual assault, and not to launder or dispose of the resident's clothing or bed linens until local law enforcement can determine whether they have evidentiary value, including encouraging the survivor not to change clothes or bathe, if he or she has not done so since the sexual assault. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care	F9999		

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F9999	Continued From page 20 needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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: 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) d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident 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	F9999		

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F9999	Continued From page 21 3-612 of the Act) THESE REGULATIONS WERE NOT MET AS EVIDENCED BY: Based on observations, record reviews and interviews the facility failed to protect and prevent a physically and mentally impaired resident (R1) from being sexually assaulted for the second time within 3 months. The facility also failed to notify the physician for immediate care after the sexual assault which resulted in delayment of medical treatment for 2 days. In addition, the facility failed to do an investigation in a timely manner, failed to notify law officials and failed to notify the state agency of a sexual assault involving 2 of 10 residents (R1,R2) reviewed for abuse. Findings Include: Review of the facility's incident report dated 3-1-12 notes the following: On 2-29-12 at about 9:30PM on the 4th floor in the dining room, staff walked into room and found R1 on the floor in a gown. R2 was positioned lying on the floor next to R1 with his shirt off but pants on. R2's medical diagnosis includes dementia, schizophrenia/paranoid type and depression. Staff redirected R2 to his room , R1 was assessed by the nurse(E11) and the nurse reported on an incident report , no signs of any trauma. The facility's incident states that the physician was notified, legal representative notified on 3-1-12 and alleged offender removed from resident contact until conclusion of investigation. The facility's incident report is dated 3-1-12 and signed by E3(Administrator) and sent to the state agency 2 days after the	F9999		

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incident on 3-2-12.

R1 was observed on 3-2-12 at 1:00PM on the 4th floor. R1 has multiple disposable adult briefs on under her clothes. R1 is not able to speak, and shuffled while walking slowly with her head down around the entire unit. R1 is not able to follow simple instructions from staff. On 3-2-12 at 2:00PM R1 was observed in her room lying on her low bed with her legs spread apart and no disposable adult brief on, staring at the ceiling.

R1's admission records note R1 is a 34 year old female admitted to the facility on 9-12-07 with the diagnoses of Huntington's disease, dementia with depression, organic mood disorder, anxiety/agitation, psoriasis and reactive airway disease.

Review of R1's care plan dated updated 3-6-12 notes R1 has deficits in the following areas, muscular-skeletal impairment, difficulty understanding, totally incontinence, cognitive deficit neurological and prone to injury related to her disease of Huntington's disease.

Review of R1's Minimum Data Set (MDS) dated 12-4-11 notes the following: speech clarity, a level 2 (no speech-absence of spoken words), make self understood a level 3 (rarely never understands), understands other a level 2 (sometimes, direct communication only) cognitive skills a level 2 (decisions poor-curs/supervision. Signs and symptoms of Delirium: inattentive and psychomotor retardation. This behavior is consistently present and does not fluctuate.

R1's care plan has unrealistic goals dated

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F9999	Continued From page 23 12-27-11 to current: supportive counseling interventions/session as needed related to information about safe sexual practice, i.e. the use of condoms and contraception methods, respectful, sensitive discrete behavior and the importance of monogamy. E15 (Assistant Administrator) stated on 3-7-12 at 2:00PM, she received a call on 2-29-12 at about 10:00PM from the nursing staff. The call was about R1 being naked below the waste and R2 kissing R1 but R2's pants were on. E15 said, "At the time I received the call I was picking up my daughter and I did not have the time to deal with it so I told the nursing staff to call E4." E12 (Staff Nurse) stated on 3-6-12 at 3:00PM, "I spoke with R2 in person the night the incident happen. R2 told me that he actually had sexual intercourse with R1. I did not tell the staff nurse on the floor, but I immediately called E4 (Assistance Administrator/Social Service Director) and told him that R2 said he had sexual intercourse with R1. E4 told me that he would deal with it in the morning." Review of R1's social service notes dated 3-1-12 at 3:38PM notes, "Nursing staff notified this writer on 2-29-12 around 10PM, that resident was found in dining room with a male peer that had his shirt removed. Male peer was wearing his pants at the time. Staff did not believe any sexual behavior had occurred but wanted to follow facility policy by reporting the incident. This writer informed staff to transfer peer to the 3rd floor during the investigation. This writer also notified staff to complete an incident report and take statements from all staff that were present."	F9999		

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Continued From page 24

E4 confirmed on 3-7-12 at 5:00PM that he wrote the note in R1's clinical records and the nursing staff did tell him of the alleged sexual abuse.

E6 (Nurse's Aide) stated on 3-2-12 at 4:30PM, she was the nurse's aide assigned to R1 on 2-29-12. E6 states she did not know the whereabouts of R1 and began looking for R1 on the entire unit. E6 stated the last time she had saw R1 was at 9:10PM. E6 said, "I found R1 at 9:30PM. She was on the floor in the small dining room with her pants and diaper off and legs open. R2 was kissing her in her mouth with his shirt off on the floor next to R1." E6 said she screamed for help. E6 said she left the room to get additional help and tell the nurse.

E11 (Staff nurse) stated on 3-2-12 at 4:30PM, "I was the nurse assigned to R1 on 2-29-12. I immediately separated the two residents and assessed R1 for any injuries. I did not see any injuries so I did not call the police." (E11 gave an explanation of how she assessed R1 on 2-29-12 by looking between R1's legs and nothing else). E11 also stated, "I called Z2 (R1's Psychiatric Physician) and he did not give any orders to send to the emergency room for further evaluation." E11 gave no comments as to why the medical attending physician was not notified nor if she notified the facility's Administration.

E6, E7, E8 and E9 (all Nurse's Aides) and E10 and E11 (both Staff Nurses) stated on 3-2-12 at 4:30PM, they all were working the evening shift when R1 had an incident on 2-29-12. No one could say for sure if R1 was not sexually assaulted/abused because of the lapse of time.

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F9999	Continued From page 25 They could not find R1 and R2 for 20 to 30 minutes. E18 (Assistant Administrator) stated that after the second incident of 2-29-12, the facility decided to put R1 on a every 15 minute monitoring programing. E18 stated that there was nothing in place after the initial sexual assault, R1 was just being monitoring on the floor by staff without any schedule, E6 (Nurse's Aide) stated on 3-2-12 that R1 is a handful because we are assigned a full load of residents to care for along with R1 and R1 wanders the entire floor and needs constant supervision all the time. E7, E8 and E9 (Nurse's Aides) and E11 (Staff Nurse) all agreed on 3-2-12 at 4:30PM with E6 related to the care of R1. E1 (Director of Nursing) on 3-7-12 at 2:00PM had no comments. Z2 stated on 3-2-12 at 5:00PM, "the nurses called me several times but they were not clear if R1 had been sexually assaulted. They told me that R1 was found in a room naked with another resident. I suggested to the nursing staff perhaps she needs to go to the emergency room but no further comments were made. I thought this was out of my scope of practice because Psychiatric physicians usually do not deal with sexual abuse in this nature." Review of R1's physician orders dated 3-2-12 at 5:30PM notes, transfer out to the hospital for sexual assault. This order came 2 days after the actual incident.	F9999		

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F9999	Continued From page 26 Z1 (Medical Attending) stated on 3-6-12 that he was not aware that R1 was alleged to be sexually assaulted on 2-29-12. Z1 said over and over again, "no one from the facility notified me." Z1 said, "if the nursing staff would have told me he would have immediately sent R1 out to the emergency room for a sexual assault medical work up and a rape kit." Z1 stated he was told last time when R1 was sexually assaulted in the facility but not this time." Z1 also told surveyor that Z2 should have notified him of the alleged sexual abuse because Psychiatric physicians do not deal with these matters, medical attending do and something would have been done right away." Review of the facility's incident report dated 11-3-11 notes R1 was sexually assaulted by another resident. R1 was sent to the hospital and a sexual assault kit was performed along with a sexual transmitted disease panel. E1 (Director of Nursing) stated on 3-7-12 at 2:00PM in the conference room, that no one called him because he was ill. The nurses know to notify E17 (Assistance Director of Nursing) if they cannot get in touch with him. E17 told surveyor on 3-2-12 at 1:30PM, she knew nothing about any incidents pertaining to R1 being sexually abused. No one in the facility told her anything, none of the nursing staff said nothing. Review of the facility's Abuse Policy notes the following: This facility prohibits mistreatment, neglect, or abuse of its residents , and has attempted to	F9999		

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establish a resident sensitive and resident secure environment. Determine if the allegation involves either physical sexual contact, involving perpetration of verbal harassment or physical contact that did not not involve penetration.
1. Do not shower, bath or change clothes of the person attacked. If clothes have been changed, save the clothes for inspections.
2. Contact the police and in cooperation with the police, have resident examined at the hospital.
3. Leave any bed linens in place, do not touch or move anything in the areas of the alleged offense, pending further direction from involved law enforcement agencies.
4. In consultation with the police, proceed with the facility's own investigation procedures....

There is no police report noting the incident of R1 on 2-29-12 at 9:30PM being sexually assaulted/abused by another resident in the facility.

E1 stated on 3-7-12 that an extensive in-service on sexual abuse was done in December, 2011 because R1 was sexually assaulted in November, 2011. The nurses and everyone else in the facility should know what to do for any allegation of abuse especially sexual abuse.

R1 was transferred to the hospital and admitted on 3-2-12 to 3-5-12 for medical care for sexual assault, sexually transmitted diseases and adjustments of her psychiatric medications.

(A)