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	145442	A. BUILDING _____ B. WING _____	10/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOULON REHAB & HEALTH CARE CENTER	HIGHWAY 17 EAST P O BOX 209 TOULON, IL 61483

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F 490	Continued From page 36 Justice Act into their Abuse Policy, did not post signage regarding the Elder Justice Act and had not educated the facility staff. The Administrator was unaware of the Act and needed to consult her corporate office. On 9/26/13 at 2:24 PM at 2:24 pm an Immediate Jeopardy was identified to have begun on 8/19/13, when facility staff failed to identify the fondling of R41's breasts by R28 as sexual abuse. On 9/26/13 at 2:30 PM E1/Administrator was notified of the Immediate Jeopardy. The surveyor confirmed through observation, record review and interview the facility took the following actions remove the Immediate Jeopardy: *The Administrator was inserviced by corporate staff regarding the facilities policies related to abuse, neglect and misappropriation of resident property. Initiated and completed 9-26-13. *The Administrator was inserviced by corporate staff regarding the Elder Justice Act. Initiated and completed 9-26-13. *The staff reporting for work for the next immediate two shifts (second and third shift) were educated by corporate staff in recognizing resident to resident abuse and facility policy regarding abuse. Initiated and completed 9-26-13. *All residents in the facility were screened for harmful behaviors using the Pre-Screening/Screening Assessment for Harmful Behaviors. Based on the screening, interventions were evaluated and modified as appropriate. Initiated 9-26-13 and completed 9-27-13.	F 490		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS	F9999		

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300.610a)
300.695a)3)
300.695b)3)
300.695c)1)3)
300.695d)
300.1210a)
300.1210b)
300.1210c)
300.1210d)1)3)6)
300.1220b)2)3)
300.3240a)

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 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 300.695 Contacting Local Law Enforcement
a) For the purpose of this Section, the following definitions shall apply:
3) Sexual abuse - sexual penetration, intentional sexual touching or fondling, or sexual exploitation (i.e., use of an individual for another person's sexual gratification, arousal, advantage, or profit).

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F9999	Continued From page 38 b) The facility shall immediately contact local law 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: 1) Ensuring the safety of residents in situations requiring local law enforcement notification; 3) Contacting police, fire, ambulance and rescue services in accordance with recommended procedure; d) Facility staff shall be trained in implementing the policy developed pursuant to subsection (c). 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 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	F9999		

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F9999	Continued From page 39 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. 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.	F9999		

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3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These requirements were not met as evidence by:

Based on record review and interview the facility failed to identify physical and sexual abuse for two of six residents (R18, R28) reviewed for abuse in sample of 18 and one resident (R33) on the supplemental sample. The facility also failed to follow it's Abuse Prohibition policy requirement of immediate notification of the Administrator and the State Agency of multiple incidents of witnessed and alleged physical and/or sexual abuse perpetrated by two of six residents (R18, R28) on the sample of 18 and one resident (R33) on the supplemental sample. The facility also failed to report a sexual assault to local law enforcement and failed to report abuse to the POA (Power of Attorney) of either the perpetrator or the victim. The facility administration failed to have knowledge of the facility's Abuse Prohibition

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policy regarding identification, reporting and investigation of potential abuse. As a result, the administration failed to provide education and instruction to subordinate staff regarding the same. These deficient practices created a systemic failure having the potential to affect all 88 residents in the facility. The facility failed to recognize R28's ongoing physical/verbal sexual harassment and one documented incident of sexual assault (fondling the breast of a demented female resident) as sexual abuse. The facility failed to identify ongoing physical aggression by R18 (punching the head of another resident on one occasion and punching the chest of a different resident on a another occasion) and R33 (hitting the jaw of one resident and striking the nose of another) as physical abuse. The facility failed to thoroughly investigate allegations of abuse and to completely document those investigations and their conclusions. The facility failed to protect residents from being abused during and after the investigations. The facility failed to be familiar with and operationalize the facility's abuse policy.

Findings include:

The CMS -672, Resident Census and Conditions of Residents, dated 9/23/13 and signed by E1 Administrator, notes the facility census to be 88 residents.
Facility policy titled "Abuse Prevention Program" with a revision date of 11/11/11 states, "Physical Abuse includes hitting, slapping, pinching, kicking and controlling behavior through corporal punishment" and "Sexual Abuse includes, but is not limited to, sexual harassment, sexual coercion or sexual assault." "..."Employees are required to immediately report any occurrences of

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potential/alleged mistreatment, neglect, and abuse of residents and misappropriation of resident property they observe, hear about, or suspect to a supervisor and the administrator"..."Supervisors shall immediately inform the administrator or his/her designated representative (specified by the administrator in the case of a planned absence) of all reports of potential/alleged mistreatment, neglect, and abuse of residents and misappropriation of resident property. Upon learning of the report, the administrator or designee shall initiate an investigation" and "A written report shall be sent to the (State Agency) initially within 24 hours and within five working days after the report of the occurrence."

1. Psychosocial Progress Notes for R28, dated 7/31/13, states, "Resident was admitted yesterday to Alzheimer's Unit. Was to be placed on the other side but for... safety...was placed on the unit. Resident was restless during the nite (sic). (R28) had inappropriate behaviors towards female residents..."

On 9/26/13 at 11:00 AM, E6/Alzheimer's Unit Coordinator stated that E6 was aware that R28 had a history of sexually inappropriate behaviors. E6/Alzheimer's Unit Coordinator stated E6 was aware of R28 yelling inappropriate sexual statements like "I want to kiss" and "Come sit on my lap." E6/Alzheimer's Unit Coordinator stated E6's plan to keep the vulnerable population of the Alzheimer's Unit safe included "redirecting" R28 and "separating the residents when needed."

Nursing Notes for R28 dated 8/4/13 at 9:15 AM, document, "Alert with usual confusion. Verbally,

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physically and sexually aggressive this AM."

Nursing Notes for R28, dated 8/4/13 at 6:05 PM, document, "Continues to be sexually inappropriate, verbally abusive and combative at times..."

On 9/25/13 at 3:06 PM, E16/RN (Registered Nurse) stated, "When (R28) was sexually inappropriate (R28) would try to grab females' breast or crotch when one walked by." E16/RN stated that R28 would masturbate wherever possible. E16/RN stated that E16 did not recall specific female residents that R28 tried to grab. E16/RN stated when R28 was sexually inappropriate E16 documented it on a 24 hour report sheet and on a behavior report sheet.

Nursing Notes for R28, dated 8/17/13 at 9:30 AM, document, "Resident up, wandering about unit. Sexually aggressive towards female residents. Frequently going to them. Not easily redirected. Found fondling female resident breast."

On 9/25/13 at 3:06 PM, E16/RN stated that E16 was passing medications and R28 walked over to R41 and lifted up R41's shirt and fondled R41's breast. E16/RN stated E16 separated R28 and R41 and "probably" charted the behaviors in the ADL (Activities of Daily Living) book. E16/RN stated that R41 "just sat there" when R28 lifted up R41's shirt and fondled R41. E16/RN stated that R41 probably did not know what was going on.

Current Care Plan for R28, dated 7/30/13, includes the following problem/need, "Resident (R28) has behaviors that others may find disruptive/socially inappropriate. Others may seek reprisal against the resident. Resident at

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times has verbally expressed sexual comments to females and has also kissed them."

Current Care Plan for R28, was not updated, includes no new interventions to address ongoing sexually inappropriate behaviors throughout R28's stay at the facility .

On 9/26/13 at 10:00 AM, E6/Alzheimer's Unit Coordinator stated (E6) "Doesn't recall updating (R28's) care plan and usually (E6) would update after every incident."

On 9/26/13 at 11:30 AM, E1/Administrator verified that E1 was not notified until 8/19/13 regarding the incident on 8/17/13 involving R28 lifting up R41's shirt and fondling R41's breast. E1/Administrator stated that the police were not notified, R41's POA (Power of Attorney) was not notified and the State Agency was not notified. E1 also stated that E1 was never notified of any other incidents of R28 being verbally, physically, or sexually inappropriate.

On 9/26/13 at 2:30 PM, Z1/Medical Director states Z1 was aware of R28's escalating behaviors, but Z1 could not recall being notified of an incident when R28 put R28's hand on another resident's breast.

A document titled, "Follow-up to behavior reported regarding (R28) touching female resident breast," dated 8/19/13 and completed by E1/Administrator, states, "Continuous monitoring was implemented with no further episodes of inappropriate fondling noted."

On 9/26/13 at 11:30 AM, E1/Administrator verified that R28 was on continuous monitoring (15

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minute checks) prior to the 8/17/13 incident and that the facility interventions did not change after the incident.

The facility failed to investigate witnessed and alleged abuse; failed to protect the residents and failed to report abuse to the Illinois Department of Public Health. One nurse indicated that he would not report an abuse allegation if it was questionable if the abuse really happened. The Administrator indicated that she would not investigate an alleged abuse between confused residents, "because you just never really know."

The Administrator completed a document titled, "Follow up to behavior reported..." The Administrator's report did not include witness statements, did not indicate that the Illinois Department of Public Health was notified and did not indicate any change in the perpetrator's interventions regarding his sexually abusive behaviors

2. Nurses Notes, dated 8/12/13 at 6:00 pm, document R33 "walked past another resident and hit (the resident) in the chest." Behavior Monitoring Record for R33 includes entry for 8/12/13 for second shift documenting "Not joking aggression, punched female resident in the chest." Current Care Plan for R33, dated 8/24/13, includes no new interventions following the 8/12/13 incident.
On 9/27/13 at 9:38 am, E2/LPN stated E21 made the entry on 8/12/13 documenting R33 hit another resident. E21 also stated E21 could not remember who R33 hit, whether E21 filled out an incident report or if E21 notified anyone.
On 9/25/13 at 1:30 pm, E1 Administrator stated, " I have nothing " and stated there are no abuse

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investigations for R27 or R33.
Nurses Notes for R27, dated 8/20/13 at 12:00 pm, document that R27 was walking to the dining room and another resident was walking in opposite direction and as they passed the peer "punched (R27) in back of head. (R27) fell onto floor onto (R27's) stomach, then rolled from side to side got to (R27's) knees and stood up." The same Nurses Notes document E1/Administrator was notified of the incident.
On 9/26/13 at 11:15 am, E16 RN (Registered Nurse) stated E16 made the entry on 8/20/13 in R27's medical record. E16 stated R33 was the resident who punched R27 in the back of the head and E16 stated E16 reported the incident to the on call Nurse and to E1/Administrator.
Current Care Plan for R33, dated 8/24/13, includes no new interventions following the 8/20/13 incident.
On 9/25/13 at 1:30 pm, E1 Administrator stated, "I have nothing" and stated that there are no abuse investigations involving R27 or R33 and that the incident on 8/20/13 was investigated as a fall. E1 Administrator also stated " They are both demented, so do you ever really know? " At that time, E1 also confirmed that R28 and R33 both were ambulatory and could have abused any of the other residents on the Alzheimer's Unit.
3. Nurses Notes for R18, dated 4/18/13 at 3:00 pm, state, "(R18) continues to be combative with staff and other residents at times." R18's Current Care Plan, dated 4/17/13, includes no new interventions following the 4/18/13 incident.
On 9/24/13 at 12:50 pm, E1/Administrator stated E1 does not have any abuse investigations and cannot recall any particular incident involving R18 for 4/18/13.
Nurses Notes for R18, dated 4/30/13 at 2:00 pm, document R8 complained "(R18) got out of bed,

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came over and hit (R8) in the left jaw and returned to bed" R18's Behavior Monitoring Record and Current Care Plan, dated 4/17/13, include no new interventions following the 4/30/13 incident.
On 9/24/13 at 3:00 pm, E18/LPN stated the documentation in R18's Nurses Notes on 4/30/13 was written by E18 and state R18 was put back to bed after supper because there were no further behaviors between 2:00 pm and supper. E18 stated E18 did not complete an incident report and did not document R18's behavior on the Behavior Monitoring Record. E18 stated, "I don't think I filled out one for this incident due to it was questionable as to whether it happened or not" E18 also stated E18 was unable to recall if E18 reported the incident to anyone.
On 9/24/13 at 12:50 pm, E1/Administrator stated E1 does not have any abuse investigations for R18 and cannot recall any particular incident for R18 on 4/30/13. E1 also stated E1 would normally do an investigation for abuse but there were no marks on R8 and E1 was unsure E1 would do an investigation if both the residents were confused. At that time, E1 confirmed that R18 was able to access all wings of the facility, except the Alzheimer's unit while in his enclosed wheel chair.
Nurses Notes for R18, dated 5/10/13 at 5:15 am, state R18 was sitting at nurses station "then resident (R18) hit at other resident (R32) striking his nose" Nurses Notes for R32, dated 5/10/13 at 5:45 am, document at 5:30 am a "nurse witnessed (R32) hit at another resident (R18). That resident then hit (R32) in the face, causing a scratch to his left upper cheek" This note also contains documentation of "on call manager notified of occurrence."
Behavior Monitoring Record for R18 includes no

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F9999	Continued From page 48 documentation of 5/10/13 5:15 am incident. Current Care Plan for R18, dated 4/17/13, includes no new interventions following the 5/10/13 5:45 am incident. Nurses Notes for R18, dated 5/10/13 at 8:25 pm, state R18 "pushed off other resident in right side of face ..." Behavior Monitoring Record for R18 does not document any behaviors for R18 on 5/10/13. Current Care Plan for R18, dated 4/17/13, includes no new interventions following the 5/10/13 at 8:25 pm incident. Nurses Notes for R32, dated 5/10/13 at 9:00 pm, document R32 was sitting at the nurses station when another resident pushed R32 in right side of R32's face. This note also documents E1/Administrator was notified of the incident. On 9/25/13 at 1:05 pm, E1/Administrator stated, "I was not aware, it is very disheartening," regarding the incident between R18 and R32 on 5-10-13 at 5:30 am and 8:25 pm. E1 verified at that time that none of the incidents involving R18 being aggressive to other residents were investigated, nor were they reported to the State Agency. (A)	F9999		