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F 000	INITIAL COMMENTS Complaint Investigation 1695361/IL88590 - F314 1695344/IL88571 - F314 1695302/IL88522 - F225, F226, F323 1695330/IL88555 - F225, F226, F323 1694229/IL87319 - No deficiency 1695246/IL88465 - No deficiency	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225		

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

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F 225	Continued From page 1 The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to thoroughly investigate to rule out the possibility of a sexual assault to a female resident and follow their policy for notification of local law enforcement after an alleged physical abuse/sexual assault. This applies to two of three residents (R1, R2) reviewed for abuse in a sample of 10. Findings include: According to a face sheet, R1 is a 61 year old female with dementia. According to R1's Minimum Data Set(MDS) assessment dated 8/15/16, R1 requires a one person physical assist for dressing. An initial incident report that was faxed to Illinois Department of Public Health (IDPH) on 9/7/16 reads: "R2 became aggressive toward R1 after R1 wandered into R2's room." The facility's final report sent to IDPH on 9/9/16 reads "R2 was discharged to the hospital for psychiatric evaluation. R2's care plan was updated for aggressive behavior. R1 sustained a scratch to her chest. First aid was applied. R1 will continue to be monitored for safety and wandering	F 225		

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behavior."
The following facility staff members were interviewed regarding this incident:
On 9/14/16 at 10:35am E6 (Certified Nursing Assistant/CNA) stated, "I was the first person to see R1 after she came out of R2's (male resident's) room on 9/7/16. I saw R1 without pants and R1 did not have any underwear on either. R2 told me that R1's pants were in his room." E6 reported, "R1 does not take her own pants off. We take them off." E6 stated, "I heard R2 say, 'I raped R1." Also, one of the nurses (E14) said to take R1 to the shower and give her a shower and have R2 take a shower right away." E6 stated, "I thought something needed to be done; maybe they shouldn't have a shower. R1 had a shower the day before. I didn't understand it. This could have been my grandmother."
On 9/14/16 at 10:50am, E11 (Certified Nursing Assistant) stated, "I was sitting on the wing where R2's room is located on 9/7/16 at approximately 3pm. I saw R1 coming down the hall with no pants or pull ups on. At the same time, R2 threw her pants in hallway. R2 was laughing and smiling. R2 stated that he had sex with R1. R2 just kept saying it. R2 knows what he is doing."
On 9/14/16 at 10:55am, E7 (Certified Nursing Assistant) stated that she was informed on 9/7/16 to give R1 a bath. E7 stated that she gave R1 a bath. E7 stated, "I noticed scratches on back, neck and fresh red marks on R1's breast and red marks like hand prints on R1's neck."
On 9/14/16 at 11am, E13 (Clinical supervisor/Social service) stated he interviewed R2 after the incident on 9/7/16. E13 stated R2 told him after the incident on 9/7/16 that he wanted to have sex with R1. R2 told E13 R1 left his room. E13 stated that there was an altercation when R2 was trying to keep R1 from leaving his

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room. E13 stated that he saw redness on R1's neck.
On 9/15/16 at 12 pm, E14 (Licensed Practical Nurse) stated she did not tell any staff member to give R1 a shower. E14 stated that she assessed R1 and observed a scratch mark on her chest. E14 stated she then gave that information to E3 (Director of Nursing).
R1's care plan dated 5/30/16 reads under Psychosocial Well-Being - "R1 is an abuse risk manifested by her wandering." R1's care plan edit date 8/25/16 reads "Psychosocial well- being - Resident may be at risk for abuse characterized by being touched inappropriately by a peer and wandering into other peer room."
The facility's abuse policy reads "This facility prohibits mistreatment, neglect or abuse of its residents by: Establishing an environment that promotes resident safety, resident security and prevention of mistreatment. Definitions - Sexual abuse includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault."
The facility's abuse policy reads "The facility shall also immediately contact local law enforcement authorities" in the following situations but not limited to:
Physical abuse involving physical injury inflicted on a resident by another resident except in situations where the behavior is associated with dementia or developmental disability.
Sexual abuse of a resident by staff member, another resident or visitor.
On 9/14/16 at 11am, E1 (Administrator) stated that she did not call the police after the incident between R1 & R2 happened on 9/7/16. On 9/16/16 at 9am, E1 stated that she is the abuse coordinator. E1 stated that she did not do a sexual abuse investigation but did a physical abuse investigation for the incident the happened

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F 225	Continued From page 4 on 9/7/17 between R1 & R2.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop an abuse policy that address the procedures staff members should take to investigate the extent of a resident injury for a possible sexual assault and failed to report to the local law enforcement a resident's sexual or physical abuse according to the abuse policy. This applies to two of three residents (R1, R2) reviewed for abuse in a sample of 10. Findings include: According to a face sheet, R1 is a 61 year old female with dementia. According to R1's Minimum Data Set (MDS) assessment dated 8/15/16, R1 requires a one person physical assist for dressing. An initial incident report that was faxed to Illinois Department of Public Health (IDPH) on 9/7/16 reads: R2 became aggressive toward R1 after R1 wandered into R2's room. The facility's final report sent to IDPH on 9/9/16 reads: R2 was discharged to the hospital for psychiatric evaluation. R2's care plan was updated for	F 226		

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aggressive behavior. R1 sustained a scratch to her chest. First aid was applied. R1 will continue to be monitored for safety and wandering behavior.
On 9/14/16 at 11am, E1 (Administrator) stated that she did not call the police after the incident between R1 & R2 happened on 9/7/16. On 9/16/16 at 9am, E1 (Administrator) stated she is the abuse coordinator. E1 reported, on 9/7/16 at approximately 3pm, R1 was seen in the hallway naked from the waist down. E1 stated that R1's pants were in R2's room. E1 stated that R2 told R1 to lay on bed and R2 went to grab R1 by the neck. E1 stated that R1 said no. E1 stated that R2 said to R1 to lay on his bed with the intent to have sex. E1 stated that R2 went to grab R1 to have sex. E1 stated that R1 said no and walked out. E1 stated "I think the nurses looked at R1 after the incident." On 9/15/16 at 12 pm, E14 (Licensed Practical Nurse) stated that she noticed a scratch, more like an abrasion, on R1's chest. E14 stated that she gave this information to E3 (Director of Nursing) and then had to go to school right away. E1 stated that she did not do a sexual abuse investigation but did a physical abuse investigation for the incident the happened on 9/7/17 between R1 & R2. E1 stated that it was not a sexual abuse but physical abuse.

The following facility staff members were interviewed regarding this incident:
On 9/14/16 at 10:35am E6 (Certified Nursing Assistant/CNA) stated, "I was the first person to see R1 after she came out of R2's (male resident's) room on 9/7/16. I saw R1 without pants and R1 did not have any underwear on either. R2 told me that R1's pants were in his room." E6 reported, "R1 does not take her own

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pants off. We take them off." E6 stated, "I heard R2 say, 'I raped R1.' Also, one of the nurses (E14) said to take R1 to the shower and give her a shower and have R2 take a shower right away. E6 stated, "I thought something needed to be done; maybe they shouldn't have a shower. R1 had a shower the day before. I didn't understand it. This could have been my grandmother."
On 9/14/16 at 10:50am, E11 (Certified Nursing Assistant) stated, "I was sitting on the wing where R2's room is located on 9/7/16 at approximately 3pm. I saw R1 coming down the hall with no pants or pull ups on. At the same time, R2 threw her pants in hallway. R2 was laughing and smiling. R2 stated that he had sex with R1. R2 just kept saying it. R2 knows what he is doing."
On 9/14/16 at 10:55am, E7 (Certified Nursing Assistant) stated that she was informed on 9/7/16 to give R1 a bath. E7 stated that she gave R1 a bath. E7 stated, "I noticed scratches on back, neck and fresh red marks on R1's breast and red marks like hand prints on R1's neck."
On 9/14/16 at 11am, E13 (Clinical supervisor/ Social service) stated he interviewed R2 after the incident on 9/7/16. E13 stated R2 told him after the incident on 9/7/16 that he wanted to have sex with R1. R2 told E13 R1 left his room. E13 stated that there was an altercation when R2 was trying to keep R1 from leaving his room. E13 stated that he saw redness on R1's neck.
On 9/15/16 at 12 pm, E14 (Licensed Practical Nurse) stated she did not tell any staff member to give R1 a shower. E14 stated that she assessed R1 and observed a scratch mark on her chest. E14 stated she then gave that information to E3 (Director of Nursing).
The facility's abuse policy reads "This facility prohibits mistreatment, neglect or abuse of its residents by: Establishing an environment that

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F 226	Continued From page 7 promotes resident safety, resident security and prevention of mistreatment. Definitions - Sexual abuse includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault." The facility's abuse policy reads "The facility shall also immediately contact local law enforcement authorities" in the following situations but not limited to: Physical abuse involving physical injury inflicted on a resident by another resident except in situations where the behavior is associated with dementia or developmental disability. Sexual abuse of a resident by staff member, another resident or visitor. Facility's abuse policy does not address any information on what the facility staff is supposed to do if they suspect a sexual assault/abuse allegation.	F 226		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to use heel protectors as care planned to prevent the development of a pressure ulcer; failed to avoid a resident's heel	F 314		

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resting directly on a wheelchair's footrest and failed to identify the onset of a resident's newly developed pressure ulcer for treatment. This applies to one of three residents (R8) reviewed for pressure ulcers in a sample of 10.

Findings include:

R8 was admitted to the facility on 10/14/15 with the following diagnoses: Alzheimer's disease, metabolic encephalopathy, non-traumatic subdural hemorrhage, hypertension and cognitive communication deficit.

On 9/20/16 at 1pm, Z2 (family) stated that on 9/14/16, she took off R8's socks because they were too small. Z2 stated that while doing this, her thumb went into R8's heel and there was a pressure ulcer on R8's heel.

On 9/20/16 at 1:15pm, E18 (Wound Nurse) stated that she was notified by R8's family member that R8 had a pressure ulcer on her right heel. E18 stated that the family does body checks on R8. E18 stated that it was the family who identified R8's facility acquired pressure ulcer on her right heel and not the staff in the nursing home.

On 9/21/16 at 8:45am, R8 was observed sitting in her wheelchair in the hallway. On 9/21/16 at 8:45am, R8's right heel was noted to have a dressing on the heel but R8's right heel slipper was off. On 9/21/16 at 8:45am, R8's right heel was directly pressing against R8's foot rest on her wheelchair. At that time, surveyor asked E18 if R8 should have heel protectors on and E18 stated "only in bed." R8's POS (Physician Order Sheet) start date 9/13/16 to open ended reads

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"Heel protectors daily to right foot with elevation, every shift; shift 1, shift 2, shift 3." On 9/21/16 at 9:05am, E19 (Certified Nursing Assistant) stated that R8 was up in the wheelchair when she arrived to work at 7am.

On 9/21/16 at 9am, E18 was observed changing R8's facility acquired stage 2 pressure ulcer dressing on R8's right heel. E18 measured R8's right heel pressure ulcer as 1 cm x 1 cm. E18 cleansed R8's right heel pressure ulcer with normal saline and applied santyl ointment then covered the pressure ulcer with gauze dressing.

R8's care plan dated 9/13/16 reads "R8 is at risk for developing pressure ulcers and fluid filled blisters related to history of blisters to lower extremities. R8 will have heel protectors on and legs will be elevated to assist with prevention of blisters to lower extremities." R8 was observed on 9/21/16 at 8:45am without heel protectors and R8's legs were not elevated. R8's heels were observed pressing directly on R8's wheelchair footrests. R8's care plan reads that R8 is at risk for developing pressure ulcers but R8's care plan dated 9/13/16 does not address that R8 currently has a facility acquired stage 2 pressure ulcer on her right heel that was identified on 9/13/16.

R8's pressure ulcer risk scale dated 9/1/16 reads "R8's score read (14)." The facility's pressure ulcer risk scale reads "14 or less = at risk for skin breakdown, over 14 = not at risk for skin breakdown."

The facility's prevention of pressure ulcers policy dated 2001 reads: "The purpose of this procedure is to provide information regarding identification of pressure ulcer risk factors and interventions for

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F 314	Continued From page 10 specific risk factors. Protect bony prominences as needed. The most common site of a pressure ulcer is where the bone is near the surface of the body including heels."	F 314		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to demonstrate how they provide enough supervision and monitoring for an ambulating dementia resident who wanders into other resident's room and failed to have a care plan in place which specifies how staff should monitor and supervise a wandering dementia resident throughout the day. This applies to one of three residents (R1) reviewed for abuse in a sample of 10. This failure resulted in R1 being physically assaulted by a male resident (R2) on 9/07/2016 Findings include: According to a face sheet, R1 is a 61 year old female with dementia. R1's clinical notes contained the following information: 1/6/16: R1 was noted going to another resident's room with pants down and unable to redirect. 2/13/16: R1 was going into other resident's room,	F 323		

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unable to redirect.
3/9/16: R1 needs constant redirection from being in other resident's room.
3/10/16: R1 frequently wanders.
5/30/16: R1 went into another resident's room. That resident asked her to get out. R1 did not and the other resident pushed her to the floor.
6/15/16: R1 wandering the halls of the facility, going in and out resident's rooms. R1 unable to be redirected. Continue to monitor frequently.
7/9/16: R1 is wandering in the corridor waiting for her mother.
8/9/16: R1 needs constant supervision and redirection due to R1 wandering throughout the facility and in peers' rooms.
8/13/16: R1 went into another resident room. The other resident grabbed R1, where R1 became agitated and physically aggressive, hitting other resident in mouth. MD notified with orders to monitor.
8/19/16: R1 needs constant supervision due to wandering and going in other residents' rooms.
8/20/16: R1 required constant supervision due to wandering and going room to room.
8/24/16: R1 observed walking throughout the unit from room to room due to wandering.
9/07/16: Report received of R1 wandering into R2's room. In an attempt to keep R1 in R2's room, R1 sustained a 0.2cm scratch to upper middle chest.
On the morning of 9/14/2016 the surveyor attempted to locate R1. On 9/14/16 at 9am, E15 (Licensed Practical Nurse) stated she did not know where R1 was at. E15 stated R1 wanders throughout the facility. The surveyor observed R1 wandering in the hallway at 9:05am.
On 9/14/16 at 9:30am, E12 (Clinical director, social services) stated R1 wanders into resident rooms. E12 stated R1 would leave her wing and

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go to other resident rooms. Staff saw R1 come out of R2's room on 9/07/16. E12 stated the plan currently in place is to supervise where R1 was; "If we see R1, people will engage her in activity."
On 9/15/16 at 12 noon, E1 (Administrator) stated the plan that is in place for R1 was constant supervision. This means the staff is to redirect R1 when they see her.
An initial incident report that was faxed to Illinois Department of Public Health (IDPH) on 9/7/16 reads: "R2 became aggressive toward R1 after R1 wandered into R2's room." The facility's final report sent to IDPH on 9/9/16 reads: "R2 was discharged to the hospital for psychiatric evaluation. R2's care plan was updated for aggressive behavior. R1 sustained a scratch to her chest. First aid was applied. R1 will continue to be monitored for safety and wandering behavior."
The following facility staff members were interviewed regarding this incident:
On 9/14/16 at 10:35am E6 (Certified Nursing Assistant/CNA) stated, "I was the first person to see R1 after she came out of R2's (male resident's) room on 9/7/16. I saw R1 without pants and R1 did not have any underwear on either. R2 told me that R1's pants were in his room." E6 reported, "R1 does not take her own pants off. We take them off." E6 stated "I heard R2 say, 'I raped R1.' Also, one of the nurses (E14) said to take R1 to the shower and give her a shower and have R2 take a shower right away. E6 stated, "I thought something needed to be done; maybe they shouldn't have a shower. R1 had a shower the day before. I didn't understand it. This could have been my grandmother."
On 9/14/16 at 10:50am, E11 (Certified Nursing Assistant) stated, "I was sitting on the wing where R2's room is located on 9/7/16 at approximately

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	145798	A. BUILDING _____ B. WING _____	C 09/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE NURSING & REHAB CTR	**1635 EAST 154TH STREET DOLTON, IL 60419**

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3pm. I saw R1 coming down the hall with no pants or pull ups on. At the same time, R2 threw her pants in hallway. R2 was laughing and smiling. R2 stated that he had sex with R1. R2 just kept saying it. R2 knows what he is doing."
On 9/14/16 at 10:55am, E7 (Certified Nursing Assistant) stated that she was informed on 9/7/16 to give R1 a bath. E7 stated that she gave R1 a bath. E7 stated, "I noticed scratches on back, neck and fresh red marks on R1's breast and red marks like hand prints on R1's neck."
On 9/14/16 at 11am, E13 (Clinical supervisor/Social service) stated he interviewed R2 after the incident on 9/7/16. E13 stated R2 told him after the incident on 9/7/16 that he wanted to have sex with R1. R2 told E13 R1 left his room. E13 stated that there was an altercation when R2 was trying to keep R1 from leaving his room. E13 stated that he saw redness on R1's neck.
On 9/15/16 at 12 pm, E14 (Licensed Practical Nurse) stated she did not tell any staff member to give R1 a shower. E14 stated that she assessed R1 and observed a scratch mark on her chest. E14 stated she then gave that information to E3 (Director of Nursing).
R1's care plan dated 5/30/16 reads under Psychosocial Well-Being - "R1 is an abuse risk manifested by her wandering." R1's care plan edit date 8/25/16 reads "Psychosocial well- being - Resident may be at risk for abuse characterized by being touched inappropriately by a peer and wandering into other peer room." R1's care plan dated 5/30/16 reads under Behavior symptoms - R1 experiences wandering. The interventions listed for wandering were "Maintain a calm environment and approach to R1. When R1 begins to wander, provide comfort measures for basic needs." Based on the care plan, the facility

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F 323	Continued From page 14 does not have a plan in place to address the supervision and monitoring for R1 due to wandering into other resident rooms to prevent possible abuse by other residents. There were no revision of the care after the incident involving R1 and R2 on 9/07/16.	F 323		