STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007439	A. BUILDING: _____ B. WING _____	08/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESENCE PINE VIEW CARE CENTER	611 ALLEN LANE ST CHARLES, IL 60174

(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) COMPLETE DATE
S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS 300.690a) 300.1210b) 300.3240a) 300.3240b) 300.3240c) 300.3240d) 300.3240f) 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. Section 300.1210 General Requirements for 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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) c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. (Section 3-610 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 3-612 of the Act) THESE REQUIREMENTS WERE NOT MET AS EVIDENCED BY: Based on record review and interview the facility failed to ensure a resident is protected from mistreatment by another resident. This resulted in R17 experiencing threat for safety, R17 afraid of R13, and R17 underwent	S9999		

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S9999	Continued From page 2	S9999		

emotion distress.

This applies to one of one resident (R17) reviewed for an allegation of mistreatment in the sample of 18 residents.

The findings include:

On August 20, 2015 at 12:15 PM, R17 stated R13 had come into her room during the night a few weeks ago and "he was undressed at the bottom." R17 said R13 had come in her room before but she always told him to get out. R17 stated R13's room was across the hall from her room. "I told the nurse's aide (CNA) about it and the aide said not to worry, he (R13) was probably disoriented. The aide confronted him though. But he came in anyway that night with no pants." (R17 stated she did not want to identify the CNA for fear of getting her into trouble. The aide is good worker.) R17 stated no one came in to ask her about the incident for at least a few days. It was E1 (administrator) who spoke with her and R17 said she told him in no uncertain terms what was going on. She was very emotional, scared and felt as a threat for her safety. R17 said after R13 came in partially naked, she barricaded herself in her room for a few nights using a chair under the door handle. She realized putting her chair against the door would interfere with the nurses work but had to do something. He (R13) stayed in the room across from her until he was discharged about two weeks later." On August 20, 2015 at 3:15 PM, R17 said she hadn't told her daughter about what happened until three days ago because she would be so upset.

A review of the most recent MDS (minimum data set) dated June 5, 2015 shows R17 is alert and oriented with no cognitive deficits. Her diagnoses

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S9999	Continued From page 3 include Parkinson's and bipolar disorder. (B)	S9999		