STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004907	A. BUILDING: _____ B. WING _____	C 09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEYVILLE NSG & REHAB CENTER	1001 SOUTH STATE STREET JERSEYVILLE, IL 62052

(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
S 000	Initial Comments Complaint Investigation 2247515/IL151383	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1010 h) 300.1210 b) 300.1210 c) 300.3210 t) 300.3240 b) 300.3240 c) 300.3240 e) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. Section 300.3240 Abuse and Neglect b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the Department and to the facility administrator. 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 and to the Department. e) 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	S9999		

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S9999	Continued From page 2 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 are not met as evidenced by: Based on observation, interview, and record review, the facility failed to prevent sexual abuse for 3 of 7 residents (R1, R2, R3); failed to notify the residents' physicians and family of an allegation of abuse in 2 of 3 residents (R2, R3); and failed to report allegations of abuse to the administrator, for 2 residents (R1 and R2) reviewed for abuse in the sample of 35. These failures resulted in an increased likelihood for physical and psychosocial harm for R1 and R2 and has the potential to affect all 34 female residents (R1, R2, R4-R35) who have benn identified by the facility as being vulnerable due to diagnoses, decreased cognition, communication deficit, or physical mobility function. Findings include: R3's MDS, dated 9/7/22, documents a brief interview of mental status of 7, indicating severely impaired cognition. The MDS documents R3 needs extensive assist with Activities of daily living. The MDS documents R3 needs supervision with locomotion on the unit. R3's undated Face Sheet documents R3 has diagnoses of Encounter for orthopedic aftercare following surgical amputation (Primary), Acquired absence of left leg above knee, Cellulitis of left	S9999		

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S9999	Continued From page 3 lower limb, Gangrene, not elsewhere classified, and Chronic obstructive pulmonary disease R3's Care plan for Category: Behaviors documents, "(R3) has sexual behavioral symptoms toward females." With the Goal: "Resident (R3) will not harm others secondary to sexually abusive behavior." Approaches dated 8/14/22 include: "Allow distance in seating other residents around resident (R3). Assess whether the sexual behavior endangers or places vulnerable females at risk. Intervene if necessary. Divert resident's behavior by moving him away from females. Obtain a psych consult/psychosocial therapy. Praise resident when behavior is appropriate. Remove resident from group activities when behavior is unacceptable. Seat resident where constant/near constant observation is possible, Set expectations and limits for (R3). When resident becomes sexually abusive or exhibits inappropriate conduct, keep distance between resident and other staff, other female residents, visitors." 1. R1's Care Plan, dated 10/10/19, documents R1 has diagnoses of Alzheimer's disease, unspecified, Dementia in other diseases classified elsewhere with behavioral disturbance, and Muscle weakness R1's Minimum Data Set (MDS), dated 7/13/22, documents R1 has a Brief Interview of Mental Status score of 7, indicating severe cognitive impairment. The MDS documents R1 requires extensive assist from staff for Activities of daily living. R1's MDS documents she is always incontinent.	S9999		

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S9999	Continued From page 4 The facility's Initial Incident Report regarding R1 and R3, for incident dated 8/14/22, submitted by V1 to IDPH on 8/14/22, documented the incident was "Inappropriate Conduct". The Report documented, "Staff reports possible resident to resident altercation. Resident separated immediately. Administrator notified immediately." The Facility's Final Report regarding the incident between R1 and R3, for incident dated 8/14/22, submitted by V1 to IDPH on 8/19/2022, documented "(R1) was sitting in the hallway when (R3) wheeled up to (R1) and exposed himself to her and requested that she make contact with his private area. No actual contact was made between (R1) and (R3). Residents were immediately separated. Residents were residing on the same hallway 3 doors apart and (R3) was moved to a different hallway. Nursing did witness. Nursing completed assessment with no injuries noted." R1's Progress Note, dated 8/14/22 at 11:48 AM, documents, "Patient was in hall sitting in chair outside of room, as this is where she sits a lot of the time. Male patient approached patient chair and proceeded to expose himself to patient. Patient turned head the other way and did not entertain said male patient. No contact was made between patients. When asked what had occurred patient (R1) responded with, he (R3) exposed himself and wanted me to touch his penis. The staff is on alert to ensure patient to patient interaction does not occur between the two. POA (Power of Attorney) was updated on situation and intervention." R1's Progress note, dated 8/15/22 at 12:58 PM, documents, "Resident has been acting out in the dining hall, aggravate other residents, clapping	S9999		

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S9999	Continued From page 5 her hands, resident was redirected, was given something to keep hands busy, resident continues to do the behavior." R1's Progress note, dated 8/16/22 at 11:40 AM, documents, "Resident continues to have her behaviors in dining hall, of clapping of the hands, resident will continue to be monitored, any changes will be made in next care plan meeting. Resident had no other complaints or concerns, happy with her care. Resident was up and eating her lunch." R1's Progress notes dated prior to 8/14/22 noted no new or worsening behaviors. On 9/21/22 at 12:00 PM, V12, Licensed Practical Nurse (LPN), stated she witnessed an act of sexual abuse against R1 from R3. V12 stated R3's room was moved, and staff were instructed to escort R3 from his room to the smoking area and back. V12 stated on 8/14/22, she was at her med cart down the hallway where R3 and R1 were sitting separately in the hallway. V12 stated she left her med cart and went down the hall to take a phone call. V12 stated when she returned to the hallway, she came up on R3 with his back to her, and R3 was facing R1. R3 had his penis and scrotum out of his pants and was touching them. V12 stated she heard R3 ask R1 to touch his penis. V12 stated R1 was facing away from R3 and did not respond to R3's question. V12 stated she separated R1 and R3 and took R3 to his room. V12 said she educated R3 on his right to masturbate in the privacy of his own room. V12 states "(R3) is pretty with it. He knows all the staff's names and knows when and where to go to smoke." V12 stated she returned to R1, and R1 stated "he had his private parts exposed and wanted me to touch them." V12 states she asked	S9999		

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S9999	Continued From page 6 R1 if R3 had touched her and R1 stated no. V12 stated she notified V1, Administrator, and moved R3 to a different room. V12 stated she notified Powers of Attorney (POAs) for both residents, but did not notify the doctors. V12 stated she was upset about the occurrence, as she feels R3 is in his right mind, and R3 purposefully targeted R1 because R1 is not cognitively intact, and R3 performed the sexual abuse act during the moment V12 had stepped away from supervision. On 9/23/22 at 10:30 AM, V2 was not able to provide any documentation that V14, R3's Physician, was notified on 8/14/22 of the sexual abuse allegation. On 9/21/22 at 12 PM, V12, Licensed Practical Nurse (LPN), stated she did not notify R3's Physician of the alleged abuse on 8/14/22. On 9/20/22 at 2:00 PM, V1, Administrator, stated he only had the initial and final report that he submitted to Illinois Department of Public Health for his investigation of R3 and R1 incident dated 8/14/22. V1 stated he had no interviews with staff and residents, or other documentation about this investigation. 2. R2's undated Face Sheet documents R2's diagnoses include, Aphasia (difficulty with communication) following unspecified cerebrovascular disease, hemiplegia and hemiparesis following cerebral infarction (stroke) affecting right dominant side, Age-related physical debility, dysphagia, oropharyngeal phase, unspecified abnormalities of gait and mobility, muscle weakness (generalized), Unspecified lack of coordination, Limitation of activities due to disability, mixed	S9999		

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S9999	Continued From page 7 receptive-expressive language disorder. R2's MDS, dated 8/11/22, documents a brief interview of mental status of 11, indicating moderately impaired cognition. It also documents R2 is dependent for activities of daily living and has a catheter. In an interview with R2 on 9/21/22 at 10:00 AM, R2 is not able to speak. Nods head yes or no. The facility's Initial Incident Report regarding R2 and R3, for incident dated 9/19/22, submitted by V1 to IDPH on 9/19/22, documents alleged resident to resident inappropriate sexual contact for R2 and R3. The Final IDPH Incident and/or Abuse Notification regarding R3 and R2, undated for incident of 9/19/2022, submitted to IDPH on 9/27/2022, documents the conclusion: staff reported possible resident to resident inappropriate sexual contact between (R3) and (R2). Staff reported that it was said by rumor that (R3) was in (R2's) room in his wheelchair sitting next to (R2's) bed and had his fingers in her vagina. Upon further investigation the incident allegedly occurred on 8/20/2022. Nurse reported on 8/20/2022 to Administrator that (R3) was in (R2) room and was found to have his hand on top of her blanket and not that any sexual contact had occurred. Residents were residing on the same hallway, (R3) was moved to a different hallway. (R3) was placed on closer watch and staff instructed to keep him out of female resident's rooms. No reporting of this incident occurred due to the incident not being a reportable event. Nursing completed assessment with no injuries noted. Upon interviewing (R3) about the incident on the night of 8/20/2022, he said nothing occurred. (R2) was interviewed on	S9999		

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S9999	Continued From page 8 the night of 8/20/2022 by the nurse on duty and flipped the nurse off while being questioned and shook her head no, that nothing happened and yes that she was okay. Interviews completed with staff working the evening of 8/20/2022, one CNA changed her story from 8/20/2022 and now reports on 9/19/2022 that in fact (R2) did have his fingers in R2's Vagina, she removed him from the room and cleaned his hands and returned to R2 to clean her up. CNA was asked why she had changed her story and CNA did not have response, only that she didn't change her story. Other staff interviewed only heard 2nd hand hearsay of the event. Police were notified of this incident and a report was completed by the (Local) Police Department. Resident sent out to (Local) Hospital on 9/24/2022 for a rape kit, results returned with 0 indications of assault. R2 was questioned a total of 4 times with each time resulting in a different response, 2 of the times resident said R3 was only in her room and no contact was made, times 3 and 4 once with daughter and once with police, R2 responded with 2 additional different answers. The first different answer was that R3 touched her stomach and breast, the second different answer with the police officer present was that R3 only touched her left leg. On 9/20/22 at 11:30 AM, V5, Certified Nursing assistant (CNA), stated on 8/20/22 around 8-8:30 PM, she witnessed R3 in R2's room. V5 stated R3 was in his wheelchair on the left side of R2's bed. V5 stated R3 had his hand in R2's vagina. V5 stated R2 was not resisting. V5 stated she told R3 to stop it, and removed R3 from the room. V5 stated R2 stuck her middle finger up in the air. V5 stated she covered R2 back up, and took R3 to the nurse station and told him to wait there. V5 stated V5 then told V6, Registered Nurse (RN),	S9999		

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S9999	Continued From page 9	S9999		

what she had witnessed. V5 stated she told V6 that V1, Administrator, needed to be called. V5 stated she took R3 to his room, and cleaned his hand up. V5 stated R3 had a small amount of bowel movement (BM) on his hands. V5 stated she then went back to R2's room and cleaned R2 up. V5 stated R2 did not have a brief on at the time of this occurrence. V5 stated she asked V6 if she told V1 what had happened, and V6 replied she had talked to V1. V5 stated she told V13, CNA, during rounds at shift change what had happened. V5 stated she did not notify or speak to V1 until 9/19/22.

On 9/20/22 at 1:30 PM, V6, RN, stated she was outside on break when V5 came outside and said she needed a nurse. V6 stated V5 told her R3 was in R2's room and had his hand on her blanket. V6 stated she interviewed R2, and R2 stuck her middle finger in the air, and started shaking her finger at V6. V6 stated R2 was covered up with her blanket and had an incontinent brief on. V6 stated, "(V5) said I had to call (V1) and I said (R3) putting his hands on (R2's) blanket is not abuse." V6 stated she did notify V1 of R3 being in R2's room and having his hand on R2's blanket. V6 stated V5 stated R3 is not to be in the female patients' rooms.

On 9/28/22 at 2:50P M, V1 stated neither R2 nor R3 have any documentation in the progress notes for 8/20/22.

On 9/20/22 at 9:30 AM, V1, Administrator, stated 3 weeks ago (no date given) he received a phone call from the RN (V6), stating R3 was in R2's room, and he was touching the bed/blanket, but did not physically touch R2. V1 stated staff intervened and removed R3 from R2's room. V1 stated he did not report anything because there

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S9999	Continued From page 10	S9999		

was no allegation of abuse because R3 did not touch R2. V1 stated now the allegation has changed to R3 putting his fingers in R2's vagina. V1 stated he didn't know why the story had changed now. V1 stated R2's story has changed multiple times.

On 9/21/22 at 2:00 PM, V13, CNA, stated on 8/20/22, V5, CNA, told her she had witnessed R3 with his fingers in R2's vagina. V13 stated V5 told her V1 was aware of this. V13 stated V5 told her to try to keep R3 away from R2.

R3's Care plan for Category: Behaviors documents, "(R3) has sexual behavioral symptoms toward females." With the Goal: "Resident (R3) will not harm others secondary to sexually abusive behavior." Approaches, dated 9/20/22, include: R3 to be monitored by all staff to prevent him from entering female resident rooms or being alone unobserved in hallway. R3 was moved to room (number) close to nurses' station.

On 9/21/22 at 9:20 AM, R3 was observed propelling himself in his wheelchair in the hallway unattended, staff active in hallway.

On 9/21/22 at 11:40 AM, R3 was alone in his room playing cards.

On 9/21/22 at 2:25 PM, R3 was observed propelling himself in his wheelchair to dining room. R3 noted sitting at table in dining with other male residents. Staff present in dining room.

On 9/23/22 at 11:40 AM, R3 was observed propelling self in hallway unattended, staff present at nurses station.

On 9/20/22 at 10:30 AM, V2, Director of Nurses

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S9999	Continued From page 11 (DON), stated V17 was not notified of the sexual abuse allegation on 9/19/22. On 9/20/22 at 10:15 AM, V4, R2's Daughter, stated yesterday she had received a phone call from V10, facility CNA, and is R2's son. V4 stated V10 was told by V13, CNA, R3 had his hands in R2's pants several weeks ago. V4 stated she spoke with V1, Administrator, after hearing this, and V1 told V4 he was only aware of R3 having his hand on R2's bed. V4 stated she came into the facility and spoke with R2 and V3, Marketing/Admissions, and R2 indicated R3 has touched her breast and thigh. V4 said she spoke with V5, CNA, and V5 said she had reported it to V13 weeks ago. V4 stated this is not the first occurrence of R3 touching other females. V4 stated V1 doesn't know anything. On 9/21/22 at 12:00 PM, V12, Licensed Practical Nurse (LPN), stated on the morning of 9/19/22, V10 told her of the occurrence between R3 and R2, so she reported it to V3, Marketing/Admissions. On 9/20/22 at 10:30 AM, V3, Marketing/Admissions, stated on 9/19/22, V12, LPN, informed her she had heard from V10, facility CNA and is R2's son, R3 had touched R2 inappropriately, and V10 wanted to know what had happened. V3 stated she immediately went to V1, Administrator, and informed V1 of the allegation. V3 then interviewed R2. V3 stated R2 had had a stroke and speaks very little, and uses hand gestures to communicate. V3 stated R2 shook her head no when asked if R3 had touched her. V3 then interviewed R2 again with V10 present, at which time, R2 shook her head no when asked if R3 had touched her. V3 then interviewed R2 with V4, R2's daughter present,	S9999		

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S9999	Continued From page 12 and R2 gestured R3 had touched her from the waist up to her breast. Local police department were notified, and police officer came to facility and interviewed R2 with V3 present. R2 indicated by gestures this time R3 had touched her thigh. On 9/21/22 at 10:15 AM, V7, CNA, stated she has not witnessed any sexual behaviors from R3. V7 stated the only intervention to address R3 was to have R3 was moved to a different room after the occurrence with R1. On 9/21/22 at 10:30 AM, V8, CNA, stated she has not witnessed any sexual behaviors from R3. V8 stated R3 was moved to a different room after the occurrence with R1, and they were supposed to monitor R3 and ensure he is not going into other residents' rooms. V8 stated R2 will ask for her curtain to be pulled, or put her covers over her head if she sees R3. V8 stated R3 has been known to touch other staff on the buttocks. V8 states R3 is very cognitive, R3 knows the staff by name, and knows when and where to go when he wants to smoke. On 9/21/22 at 10:40 AM, V9, CNA, stated she has not witnessed any sexual behaviors from R3. V9 stated R3 was moved to a different room after the occurrence with R1. V9 stated they are supposed to keep R3 from wandering into other rooms by re-directing him. On 9/21/22 at 11:00 AM, V10 stated he has not witnessed any sexual behaviors from R3, but he is aware of an incident between R3 and R1. V10 stated R3 was moved to a different room after the occurrence with R1, and they were supposed to keep R3 away from R1. V10 stated V13 asked him on the morning of 9/19/22 what had happened with the situation between R3 and R2.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004907	A. BUILDING: _____ B. WING _____	C 09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 13 V10 stated V13 told him R3 had been witnessed in R2's room with R3's fingers in R2's vagina by V5 several weeks ago. V10 stated he called V4 and informed her. V10 stated V13 said V5 reported it to V1. V10 stated R2 was doing good in therapy when she first got here, but in the last few weeks R2 has not been doing as well. V10 stated R2 has just shut down; R2 tears up a lot now. V10 stated, "(R2) has had a change in her behavior over the last two and half weeks, she isn't as interested in her nieces as she used to be, she used to cuddle with them, and she doesn't want anything to do with them." V10 states R2 isn't eating or speaking like she did a couple of weeks ago, V10 believes these changes are due to the occurrence with R3. On 9/21/22 at 11:45 AM, V11, CNA, stated she has not witnessed any sexual behaviors from R3. V11 stated the only interventions to address R3's behavior was to have R3 was moved to a different room after the occurrence with R1. On 9/21/22 at 2:30 PM, V1 states the interventions that were put in place after the 8/14/22 incident with R3 and R1 included staff to monitor resident closely, if R3 is in hallway they are to monitor him, room moves, and to re-direct him. V1 states staff are to engage R3 in activities to keep him active. V1 states they have done a medication review, and updated the doctor on 9/19, and on 9/20/22 doctor ordered new medication. V1 stated the staff member that witnesses the abuse is to call him, but they are allowed to use the chain of command to notify him also. V1 stated he did not speak with V5 on 8/20/22. V1 stated he had a conversation with the POA of R3 on 9/21/22, and informed him the sexually inappropriate behavior could lead to a discussion about alternative placement for R3.	S9999		

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S9999	Continued From page 14 On 9/23/22 at 11:00 , V1 stated he is not aware of any assessment of R3s sexual behavior that has been completed for vulnerable females who are at risk, as stated in R3's care plan dated 8/14/22. V1 stated he did speak with V5 on 8/20/22, and V5 stated R3 had only touched R2's blankets, but V5 felt like R3 was working on being inappropriate with R2. V1 stated his final report on the 8/14/22 report was unsubstantiated because they could not determine R3 had intent to sexually abuse R1. V1 stated there has been no changes to R1's or R2's behaviors. On 9/23/22 at 11:20 AM, V5 stated she did not speak with V1 on 8/20/22. V5 stated the first time she spoke to V1 about the sexual abuse allegation was on 9/19/22. V5 stated she didn't think she was supposed to call V1. V5 stated she was not aware of where to find V1's phone number to call him. V5 stated she has been suspended. On 9/28/22 at 10:45 AM, V10, R2's Son/CNA, stated he was not notified of the alleged abuse involving R2 until 9/19/22, when he was told by another CNA. On 9/28/22 at 10:45 AM, V4, R2's Daughter, stated she was not notified of the alleged abuse involving R2 until 9/19/22, when V10, R2's Son/CNA, notified her. R2's Progress Notes were reviewed with no documentation of the alleged abuse on 8/20/22 or 9/19/22, when the alleged abuse was reported, or that V17, R2's Physician, or V4 were notified. On 9/23/22 at 12:50 PM, V14, R3's Physician,	S9999		

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S9999	Continued From page 15 stated he was not aware of the sexual abuse incidents on 8/14/22 or 8/20/22 until the week of 9/19/22. V14 stated had he known about the sexual abuse allegation on 8/14/22, he might have done something different for R3's sexual behaviors. V14 stated he has started R3 on Zoloft for his sexual behaviors. On 9/28/22 at 2:50 PM, V1, Administrator, states they have 34 residents identified as vulnerable related to R3's sexual behaviors. V1 states they are all female residents who have a cognitive impairment, communication deficit and/or physical limitations. V1 gave surveyor a list of residents who are identified as R1, R2 and R4 through R35. The Resident Information Report labeled List of Female Residents Cognitively Impaired, Communication Deficit, and Physical Limitations provided by V1 on 9/28/22 lists R1, R2, and R4-R35. The facility's Abuse Prevention Program policy and procedure, revised 12/16/2016, documents definitions, "Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish." It continues, "Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology." It also documents, "Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm." It documents the definition "Sexual abuse is non-consensual sexual contact of any	S9999		

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S9999	Continued From page 16 type with a resident." It also documents, "5. Internal Reporting Requirements and Identification of Allegations - Employees are required to report any incident, allegation, or suspicion of potential abuse, neglect, or misappropriation of property they observe, hear about, or suspect immediately to the administrator. Upon learning of the report, the administrator shall initiate an incident investigation.6. Protection of Residents The facility will take steps to prevent further potential abuse, neglect exploitation, or mistreatment while the investigation is in progress a. Residents who allegedly mistreated another resident will be removed the situation and have limited contact with the targeted individual during the course of investigation. The accused resident's condition shall be immediately evaluated to determine most suitable therapy, car approaches, and placement, considering his/her safely, as well as the safety of other residents and employees of the facility.7. Internal investigation of abuse, neglect or misappropriation allegations and response. a. All incidents will be documented, whether or not abuse occurred, was alleged or suspected. b. Any incident or allegation involving abuse, neglect, or misappropriation will result in an abuse investigation. c. Any other incident or pattern involving 'reasonable cause to suspect abuse, neglect, or misappropriation', will result in an abuse investigation." It also documents, under d. Confidentiality. "After a conclusion of the investigation, internal reports, interviews, and witness statements shall be release only with the permission of the administrator or the facility attorney." Under f. Final Abuse Investigation Report, documents, "Attach a summary of all interviews conducted, with names, addresses, phone number and willingness to testify of all witnesses."	S9999		

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S9999	Continued From page 17 (A)	S9999		