Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007876	A. BUILDING: ____ B. WING ____	C 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOWNERS GROVE REHAB & NURSING	3450 SARATOGA AVENUE DOWNERS GROVE, IL 60515

(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 Investigation of Complaint # 2371701/IL156965.	S 000		
S9999	Final Observations Statement of Licensure Violations: 330.910b) 330.1510 a)4) Section 330.910 Personnel b) Sufficient staff in numbers and qualifications shall be on duty all hours of each day to provide services that meet the total needs of the residents. As a minimum, there shall be at least one staff member awake, dressed, and on duty at all times. Section 330.1510 Medication Policies a) Every facility shall adopt written policies and procedures for assisting residents in obtaining individually prescribed medication for self-administration and for disposing of medications prescribed by the attending physicians. These policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility. 4) If the facility elects to administer medications to some residents for control purposes, the medications shall be administered by personnel who are licensed to administer medications, in accordance with their respective licensing requirements. Medications shall not be recorded as having been administered prior to their actual administration to the resident. The REQUIREMENT was not met as evidenced	S9999	Attachment A Statement of Licensure Violations	

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

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S9999	Continued From page 1 by: Based on interview and record review, the facility failed to administer scheduled medications to residents and the facility failed to have a nurse on duty to provide residents care including medication administration. This applies to 3 of 3 residents (R101, R102, R103) reviewed for medication administration and resident care in a sample of 3. The findings include: 1. The EMR (Electronic Medical Record) showed R101 was admitted to the facility on April 20, 2022, with multiple diagnoses including hypertension, right eye blindness, and benign prostatic hyperplasia. The EMR continued to show the following order for morphine sulfate (pain medication) oral solution 20 mg (milligrams) per 5 mL (milliliters), give 0.25 mL by mouth every four hours for pain. On March 6, 2023, at 12:00 PM, V1 (Administrator) said there is a nurse in the facility 24 hours a day. V2 (DON/Director of Nursing) said the nurse pulls out the residents' medication and gives the medications to the residents to take. On March 6, 2023, at 4:25 PM, V30 said there was not a nurse in the facility on February 25, 2023 night shift into February 26, 2023. On March 7, 2023, at 2:55 PM, V30 said she was aware the evening shift did not have a nurse and she notified V29. V30 continued to say she reached out to V39 (LPN/Licensed Practical Nurse), the night shift nurse, to see if she could	S9999		

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come in early, but she said she could not. V30 said V39 did not come in for the night shift and did not call in to her.

On March 13, 2023, at 1:50 PM, V29 (Director of Wellness) said on February 25, 2023, at 3:17 PM, V29 received a call from V30 (Staffing Coordinator) that the evening nurse called off and there was not a nurse for the facility. V29 continued to say the night shift nurse did not show up because she was not actually scheduled. V29 said there was not a nurse through the night of February 25, 2023 into February 26, 2023. V29 continued to say during the day on February 26, 2023, V40 (RN/Registered Nurse) came over from the skilled nursing facility to work in the sheltered facility, but V29 was unsure what time V40 arrived to the sheltered facility.

On March 13, 2023, at 2:37 PM, V29 (Director of Wellness) said, "Since there was no nurse working in the facility on the evening shift February 25, 2023, and night shift into February 26, 2023, the residents did not receive their medications."

On March 14, 2023, at 9:16 AM, V37 (Hospice Supervisor) said hospice received a call from R101's daughter that R101 had not received his scheduled pain medication. V37 continued to say V38 (Hospice Nurse) went to the facility on February 26, 2023, at 9:25 AM and there was not a nurse in the facility.

R101's February MAR (Medication Administration Record) showed On February 25, 2023, R101 did not receive morphine as ordered 4:00 PM and 10:00 PM. The MAR continued to show, on February 26, 2023, R101 did not receive

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S9999	Continued From page 3 morphine at 12:00 AM, 4:00 AM, and 8:00 AM. On March 14, 2023, at 9:16 AM, V37 (Hospice Supervisor) said she received a phone call on February 25, 2023, at 9:35 AM from V38 (Hospice Nurse) and was told there was not a nurse in the facility. V37 said when V38 assessed R101, he was in pain and had facial grimacing, restlessness, and an increased respiratory rate. A progress note dated February 26, 2023, at 3:07 PM, by V40 showed "Patient is deceased. Patient passed away at 12:32 PM. Hospice nurse contacted with family." A hospice progress note dated February 26, 2023, at 10:56 AM, by V38, showed "At 07:55 AM, author received answering service message to call [R101]'s daughter, as she had concerns her father did not get pain medication. Returned [R101's daughter]'s call at 7:58 and spoke with her. States she phoned [facility] at 3:00 AM to check on [R101], but when she asked to speak to the nurse, she states she was told 'there is no nurse tonight' and then stated the person 'hung up on me.' At approximately 9:25 AM, upon author's arrival to front desk for sign in, author asked the desk clerk who the nurse was who was assigned to [R101], she said there is no nurse yet ... Upon arrival to patient's room, patient is lying supine, semi fowlers position. He is mouth breathing and initially unresponsive to verbal and tactile stimulation, however quickly became responsive by facial grimacing, moving head side to side and moving his right upper extremity ... At 9:35 AM, phoned [V37] and informed of scenario in its entirety and confirmed with her that author has authority to as hospice nurse to medicate patient with hospice ordered medications, if able	S9999		

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S9999	Continued From page 4 to access ... at 9:57 AM, phoned and updated [V37], CNA (Certified Nursing Assistant) just made aware of narcotic keys located. [V37] stated okay to administer patient his morphine, as per hospice orders. This was done and witnessed by CNA ..." 2. R102's EMR showed R102 was admitted to the facility on October 24, 2020, with multiple diagnoses including: hyperthyroidism, heart failure, and left eye visual loss. The EMR continued to show the following order for gabapentin (nerve pain medication) oral capsule 300 mg, give one capsule by mouth three times a day for neuropathy. R102's February 2022 MAR showed, R102 did not received her scheduled gabapentin (nerve pain medication) on February 25, 2023 at night and February 26, 2023 in the morning or at noon. 3. R103's EMR showed R103 was admitted to the facility on April 14, 2018, with multiple diagnoses including: spinal fracture, dementia, low back pain, spinal stenosis, insomnia, multiple wedge compression fractures of the spine. The EMR continued to show the following orders: tramadol (pain medication) 50 mg tablet, give half tablet by mouth at bedtime related to spinal fracture; tramadol 50 mg, give one tablet by mouth one time a day related to spinal fracture; tizanidine (muscle relaxer) 2 mg tablet, give one tablet by mouth two times a day related to spinal fracture; and acetaminophen 650 mg extended release tablet, five one tablet by mouth three times a day related to spinal fracture. On March 13, 2023, at 2:46 PM, R103 said, "Sometimes I do not get my medications. I have	S9999		

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S9999	Continued From page 5 back pain and take pain pills for the pain. It is not good if I skip a dose of pain medication because then the pain gets too bad." R103's February 2022 MAR, showed, On February 25, 2023, R103 did not receive tizanidine or acetaminophen in the evening or tramadol at bedtime as ordered. The MAR continued to show, on February 26, 2023, R103 did not receive tizanidine, tramadol, or acetaminophen in the morning as ordered. The facility did not have a policy for medication administration. The facility did not have a policy for personnel. (B)	S9999		

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S 000	Initial Comments Facilty Reported Incident of February 15, 2023/ IL156990	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.3210t) 300.3240a) 300.3240b) 300.3240c) 300.3240f) 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 300.1210 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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 300.3210 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 a) An owner, licensee, administrator, employee or 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 Department and to the facility administrator. (Section 3-610(a) 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 and to the Department. (Section 3-610(a) of the Act) f) A facility that becomes aware of photographing or recording of a resident, without the resident's consent or knowledge, or any other abuse, shall comply with subsections (a) through (e) of this Section. These requirements are not met as evidenced by:	S9999		
	Based on interview and record review the facility			

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S9999	Continued From page 2 failed to keep residents free from sexual abuse and exploitation by V3 (Former Housekeeping Staff). R1, R3, R4 and R5 had sexually explicit videos and photographs taken of them by V3 in October 2022 and November of 2022. The facility failed to conduct a comprehensive investigation of these incidents and report these to the local police. The facility failed to ensure that residents exposed to abuse were kept safe for any additional abuse and take measures to ensure that additional residents were not exposed to abuse. The facility failed to implement their policy to thoroughly investigate an allegation of employee to resident sexual abuse and prevent further abuse or mistreatment from occurring. The facility failed to validate sexual abuse and implement training after an allegation of sexual abuse. This failure resulted in, facility staff identifying R1, R3, R4, and R5 as residents explicitly photographed by V3 (Former Housekeeping Staff) when V11 (Police Detective) came to the facility on February 15, 2023 and reported a sexual abuse investigation into V3. The facility also had an anonymous letter sent to them, dated October 12, 2022, regarding V3 and his past history of sexual abuse in the facility. This failure resulted in V3 taking sexually explicit videos and photographs involving R1, R3, R4, and R5 that was reported to the facility by V11 (Police Detective) on February 15, 2023. The facility also has an anonymous letter sent to them dated October 12, 2022, regarding V3 and past history of sexual abuse in the facility. V3's date of hire was October 11, 2022, and was suspended on November 18, 2022, after V22 (Former Administrator) became aware of the letter, and V3 later resigned.	S9999		

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The facility failed to implement their Abuse policy and procedure and conduct a comprehensive investigation of the event and report the abuse to the state health department.

This applies to 4 of 7 residents (R1, R3, R4, and R5) reviewed for sexual abuse in a sample of 7.

The findings include:

The facility submitted a preliminary abuse incident investigation report on February 15, 2023, in which the facility was notified by V11 (Police Detective) of an investigation of sexual abuse in the community. V11 informed the facility that during this investigation, V3 (Former Housekeeping Staff) was identified as the alleged offender and the police found multiple explicit pictures of male residents of the facility. The report continued to document that V3 was employed by the facility from October 11, 2022, until V3 was terminated on November 21, 2022. The facility documents in the initial report that all males that resided in the facility at the time of this incident that are cognitively able to be interviewed will be interviewed and assessed for injury and trauma. The facility continued to add that resident representatives, physicians and local law enforcement were also notified of the event and that the facility would conduct a "complete and thorough investigation."

The facility submitted the final report to the department on February 22, 2023. The undated report documents, "FINAL: Unable to substantiate at this time. Police investigation is still ongoing with facility cooperation. All possible effected residents interviewed and no corroboration of alleged events. Trauma assessment and

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psychosocial counseling provided. Families notified about alleged incident in coordination with local law enforcement."

On March 8, 2023, at 9:07 AM, V1 (Administrator) said V11 (Police Detective) came to the facility on February 15, 2023 and told V1 he was investigating a case in the community involving V3. V1 said V11 said the police had V3's cellphone and there were photographs of sexual abuse on V3's cellphone, oral in nature. V1 said the facility identified four residents (R1, R3, R4, and R5) from the photographs provided by V11 as being the residents explicitly photographed by V3. V11 stated on March 14, 2023, that R2 was not one of the victims on the video. V1 continued to say he did not interview any staff members during this investigation. V1 said none of the residents said they were photographed so abuse was unsubstantiated. V1 continued to say this would not be abuse because he did not know if the photographs were consensually.

1. R1's EMR (Electronic Medical Record) showed R1 was admitted to the facility on August 9, 2017, with multiple diagnoses including stroke affecting the left side, epilepsy, vascular dementia, depression, and aphasia.

R1's MDS (Minimum Data Set) dated January 6, 2023, showed R1 had severe cognitive impairment. The MDS continued to show R1 required extensive assistance of facility staff for toilet use, personal hygiene, eating, dressing, and bed mobility.

As of March 6, 2023, at 1:01 PM, R1's care plan did not show a care plan for abuse.

On March 7, 2023, at 1:49 PM, V11 (Police

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S9999	Continued From page 5 Detective) said he was conducting an investigation of a sexual abuse allegation in the community and V3 was the perpetrator. V11 continued to say V3's cellphone was searched by police, and V3 had multiple nude photographs and nude video recordings of males. V11 said the photographs and videos had data to show they were taken at the facility. V11 said V3 took three videos of R1, which included two videos on November 5, 2022, at 6:11 PM and 6:15 PM of V3 washing R1, and one video on November 15, 2022, at 6:52 AM of R1's genitals. V11 continued to say V3 admitted to taking the nude photographs and videos of the residents. On March 6, 2023, at 2:47 PM, R1 was not interviewable. R1 would shrug his shoulders when asked questions. 2. R3's EMR showed R3 was admitted to the facility on November 14, 2019, with multiple diagnoses including stroke affecting the right side, depression, dementia, and aphasia. R3's MDS dated February 17, 2023, showed R3's cognitive skills for daily decision making was severely impaired. The MDS continued to show R3 required extensive assistance from facility staff for bed mobility, dressing, toilet use, and personal hygiene. As of March 6, 2023, at 1:47 PM, R3's care plans did not show a care plan for abuse. On March 7, 2023, at 1:49 PM, V11 said V3 took multiple three second videos of R3's genitalia on November 5, 2022. V11 continued to say on November 13, 2022, at 7:48 PM, V3 took a photograph of R3's genitals and then took a video of V3 performing oral sex on R3.	S9999		

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On March 6, 2023, at 2:55 PM, due to R3's cognitive impairment, R3 could not be interviewed.

On March 8, 2023, at 3:26 PM, V23 (LPN/Licensed Practical Nurse) said she remembered V3 working at the facility. V23 continued to say when V3 worked at the facility she remembered him spending a lot of time in R3's room. V23 said, "It was like [V3] favored [R3]."

3. R4's EMR showed R4 was admitted to the facility on November 21, 2021, with multiple diagnoses including: chronic obstructive pulmonary disease, dementia, dysphagia, legal blindness, and heart failure.

R4's MDS dated September 9, 2022, showed R4 had moderate cognitive impairment. The MDS continued to show R4 was totally dependent on facility staff for transferring, toilet use, personal hygiene, and locomotion on and off the unit.

R4's care plan did not show an abuse care plan.

On March 7, 2023, at 1:49 PM, V11 said on November 1, 2022, at 9:45 AM, V3 took a video of V3 touching R4's genitals. V11 continued to say V3 took a video on November 13, 2022, at 5:15 PM of V3 performing oral sex on R4. V11 said V3 took a video on November 16, 2022, at 7:52 PM, of V3 washing R4 and R4's genitals were exposed.

4. R5's EMR showed R5 was admitted to the facility on July 30, 2021, with multiple diagnoses including: hemiplegia and hemiparesis following intracerebral hemorrhage affecting the left side,

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dementia, and pneumonia.

R5's MDS dated October 8, 2022, showed R5 had severe cognitive impairment. The MDS continued to show R5 required extensive assistance from facility staff for bed mobility, transfers, dressing, toilet use, and personal hygiene.

R5's care plan did not show an abuse care plan.

On March 7, 2023, at 1:49 PM, V11 said V3 took a video on October 22, 2022, at 6:23 PM of V3 touching R5's genitals. V11 continued to say V3 took another video at 6:36 PM of V3 touching R5's genitals. V11 said V3 took a video on October 30, 2022, at 4:59 PM, of V3 performing oral sex on R5.

On March 8, 2023, at 10:55 AM, V1 said V3 was suspended on November 18, 2022, because V22 (Former Administrator) received a letter about sexual abuse allegations about V3.

On March 14, 2023, at 3:51 PM, V11 said "I did not tell the facility what to do, I told them they had their own protocol to follow, and ultimately it is their situation to investigate. I would not tell them what to do because it is their facility to run."

On March 7, 2023, at 3:07 PM, V15 (Former Human Resources) said she worked as human resources starting around November 2022, and prior to working in human resources, she worked at the front desk. V15 said she received an anonymous letter while V3 was employed at the facility in October 2022 or November 2022. V15 continued to say the letter alleged V3 committed sexual abuse to residents. V15 said she opened the letter and immediately brought it to V22

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S9999	Continued From page 8 (Former Administrator). The facility does not have documentation to show an investigation was completed in November 2022 for the allegations against V3. On March 8, 2023, at 3:26 PM, V23 (LPN/Licensed Practical Nurse) said she remembered V3 working at the facility. V23 continued to say when V3 worked at the facility she remembered him spending a lot of time in R3's room. V23 said, "It was like [V3] favored [R3]." V23 continued to say she had never been interviewed by anyone in the facility regarding V3. On March 8, 2023, at 10:08 AM, V6 (RN/Registered Nurse) said she has worked at the facility for six years. V6 said she worked with V3 in October 2022 and November 2022. V6 continued to say she was never interviewed by the facility about working with V3. V6 said she had not received abuse training since August 2022 and had not received any training regarding taking pictures of residents. On March 8, 2023, at 10:12 AM, V7 (RN) said she has worked at the facility for eight years. V7 said she worked with V3 in October 2022 and November 2022. V7 continued to say she was never interviewed by the facility about working with V3. V7 said she had not received any training on taking pictures of residents. On March 8, 2023, at 10:14 AM, V17 (Housekeeper) was interviewed with V18 (Agency CNA/Certified Nursing Assistant) translating. V17 said she has worked at the facility for three years. V17 continued to say she worked with V3 in October and November 2022 but was never interviewed by the facility about him. V17 said	S9999		

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she received abuse training when she started three years ago but has not had any training since.

On March 8, 2023, at 10:24 AM, V19 (RN) said she has worked at the facility for three years. V19 said she worked with V3 in October 2022 and November 2022. V19 continued to say she was never interviewed by the facility about working with V3. V19 said she could not remember the last time she received abuse training, but it was at least two years ago. V10 continued to say she did not receive training about taking pictures of residents.

On March 8, 2023, at 10:27 AM, V20 (Agency CNA) said he has worked regularly at the facility for the past two to three months. V20 continued to say the facility has not provided him abuse training or training about taking pictures of residents.

On March 7, 2023, at 3:22 PM, V14 (RN) said she has worked at the facility for 15 years. V14 continued to say no one has interviewed her about V3.

On March 7, 2023, at 3:26 PM, V32 (LPN) said she has worked at the facility for 14 years. V32 continued to say no one has interviewed her about V3.

The facility's undated policy titled "Abuse," showed, "POLICY: This organization recognizes and respects that each resident has the right to be free from abuse, neglect, misappropriation of resident's property, and exploitation as defined in this subpart. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint

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S9999	Continued From page 10 not required to treat the resident's medical symptom. The facility is committed to developing and operationalizing policies and procedures for screening and training employees, protection of residents and for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, and misappropriation of property. DEFINITIONS: 'Abuse'- is the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish. Abuse also includes deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, can 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. 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 ... 'Sexual abuse'- is non-consensual sexual contact of any type with a resident. SPECIFIC PROCEDURES/GUIDANCE: ...2. Training ... d. At a minimum, education on abuse, neglect, exploitation will be provided to facility staff upon hire and annually. In addition to the freedom from abuse, neglect, mistreatment of residents, misappropriation of property and exploitation requirements in 483.12, the organization will also provide training to their staff on: i. activities that constitute abuse, neglect, exploitation, and misappropriation or resident	S9999		

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property as set forth at 483.12.
ii. Procedures for reporting incidents of abuse, neglect, mistreatment, exploitation, or the misappropriation of resident's property.
iii. Dementia management and resident abuse prevention ...

3. Prevention
a. The facility will not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion....
f. A comprehensive assessment and individualized care plan will be developed for each resident to assist staff in providing effective interventions to prevent abuse, meet the resident's needs and promote quality of life ...

4. Identification
a. During orientation and annually at a minimum, staff will be educated on observation and reporting important information about resident care, condition or behavior. Staff are encouraged and protocols will be maintained to promote timely identification and reporting of events such as suspicious bruising or residents, occurrences, patterns, and trends that may constitute abuse; and to determine the direction of the investigation.
b. Staff are encouraged to identify, correct, and intervene in situations in which abuse, neglect and/or misappropriation of resident property is likely to occur. Immediately following ensuring the resident's safety, staff are to report any allegation or observation of abuse to their supervisor, director of nursing, administration or facility leadership member.
c. Resident and environmental rounds will be conducted periodically throughout the day. These rounds and frequent monitoring are to ensure resident needs are being met in accordance with

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the plan of care, that residents are being supervised and that the environment is free of hazards.
d. Administrative and facility leadership staff will supervise staff to identify inappropriate behaviors, action and response to resident needs.

5. Investigation
Designated staff will immediately review and investigate all allegations or observations of abuse.
a. the results of all investigations are to be communicated to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within five working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
b. The organization will conduct analysis for trends and patterns related to incidents [i.e., falls, skin tears, bruising or injury of unknown origin, unusual occurrences, reportable incidents, etc.].
c. Outside investigative bodies, such as the local police will be contacted as directed by the administrator or his or her designee and in accordance with federal, state, and local law.
d. The Quality Assurance/Performance Improvement Committee will monitor trends and patterns for needed changes in facility policy, practice or protocols.

6. Protection
... b. The resident's plan of care will be revised to reflect interventions to minimize recurrence and to treat any injury or harm identified through assessment of the resident.
c. Other residents who may have potentially been affected or at risk will be identified and a plan of care will be developed or revised as appropriate to ensure their safety.

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S9999	Continued From page 13 ...e. The facility Quality Assurance/ Performance Improvement Committee will review and provide recommendation for unusual occurrences. An unusual occurrence or incident may include, but not be limited to: elopement, self-inflicted injury that is life threatening, suicide, ingestion of poison, violent behavior that cannot be re-directed and/or results in injury requiring transfer to an Emergency Room or hospital [i.e., rape, fracture, death, etc.] and other unusual incidents that require reporting to regulatory, investigative, or legal entities ..." The undated facility policy title, "Abuse Investigation and Reporting," showed, "POLICY: All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source ('abuse') shall be promptly reported to local, state, and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. SPECIFIC PROCEDURES/GUIDANCE Role of the Administrator- 1. If an incident or suspected incident of resident abuse, mistreatment, neglect, or injury of unknown source is reported, the Administrator/designee will assign the investigation to an appropriate individual. 2. The Administrator/designee will provide any supporting documents relative to the alleged incident to the person in charge of the investigation. 3. The Administrator/designee will keep the resident and his/her representative Informed of the progress of the investigation. 4. The Administrator/designee may suspend	S9999		

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immediately any employee who has been accused of resident abuse, pending the outcome of the investigation.
5. The Administrator/designee will ensure that any further potential abuse, neglect, exploitation or mistreatment is prevented.
6. The Administrator/designee will inform the resident and his/her representative of the status of the investigation and measures taken to protect the safety and privacy of the resident.

Role of the investigator-
1. The individual[s] conducting the investigation may, at a minimum:
a. Review the completed documentation forms;
b. Review the resident's medical record to determine events leading up to the incident;
c. Interview the person(s) reporting the incident;
d. Interview any witnesses to the incident;
e. Interview the resident (as medically appropriate);
f. Interview the resident's Attending Physician/Practitioner as needed to determine the resident's current level of cognitive function and medical condition;
g. Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident;
h. Interview the resident's roommate, family members, and visitors;
i. Interview other residents to whom the accused employee provides care or services; and
j. Review all events leading up to the alleged incident.

2. The following guidelines may be used when conducting interviews:
... d. Witness reports will be obtained in

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writing. Either the witness will write his/her statement and sign and date it, or the investigator may obtain a statement, read it back to the member and have him/her sign and date it ...

Reporting-
1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies:
   a. The state licensing/certification agency responsible for surveying/licensing the facility;
   b. The local/State Ombudsman;
   c. The Resident's Representative (Sponsor) of Record;
   d. Adult Protective Services (where state law provides jurisdiction in long-term care);
   e. Law enforcement officials (if applicable);
   f. The resident's Attending Physician; and
   g. The facility Medical Director.
2. An allegation of abuse, neglect, exploitation, or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but no later than:
   a. Two hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or
   b. Twenty-four hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury.

3. Verbal/written notices to agencies may be submitted via special carrier, fax, e-mail, or by telephone, in accordance with state regulations/guidelines ..."

(A)