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
	IL6008205	A. BUILDING: ______ B. WING ______	C 02/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN REHAB & HEALTH CARE	1403 9TH AVENUE SILVIS, IL 61282

(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 300.610a) 300.690b) 300.690c) 300.1210b) 300.3240a) 300.3240d) 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 300.690 Incidents and Accidents b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 03/04/15

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Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.

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 agent of a facility shall not abuse or neglect a resident. (Section 2-107 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

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3-612 of the Act)

These requirements are not met as evidenced by:

Based on interview, record review and observation, the facility failed to follow its policy on reporting an incident of sexual assault, failed to report an incident of sexual assault timely to the facility Administrator, failed to investigate an incident of sexual assault, failed to report an incident of sexual assault to the State Agency, as required by the facility's Abuse Prevention Policy, and failed to prevent further abuse during an investigation involving R3, one of six residents reviewed for abuse in the sample of six. This neglect resulted in R3 sexually abusing R5 once and R6 twice. This failure has the potential to affect all 40 female residents (R1, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, R20, R21, R22, R23, R24, R25, R26, R27, R28, R29, R30, R31, R32, R33, R34, R35, R36, R37, R38, R39, R40, R41, R42) currently in the facility.

Findings include:

The facility policy titled "Abuse Prevention Program" dated (revised) 11/11/11 documents, "Employees are required to immediately report any occurrences of potential/alleged mistreatment, neglect and abuse of residents and misappropriation of resident property they observe, hear about, or suspect to a supervisor and the administrator...Upon learning of the report, the administrator or designee shall initiate an investigation...The report shall be made to (the state agency) immediately after forming the suspicion. Otherwise, the report must be made not later than 24 hours after forming the suspicion...Residents who allegedly mistreat or

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abuse another resident or misappropriate resident property will be removed from contact with that resident during the course of the investigation."

Nurses Notes dated 8/20/2014 at 9:30A.M. from R3's previous nursing home found in R3's current medical record states," Resident (R3) observed with his hand on inner thigh of resident #0022.Wife notified of incident and explained we would have to look for other placement."

R3's "Interdisciplinary Discharge Summary" from a local nursing home indicates that R3 was admitted to the present facility on 09/02/14. The reason for discharge indicates, "Unable to meet resident's needs."

The facility "Nursing Admission Assessment" dated 09/02/14 indicates R3 is "Alert, Cooperative, Identifies: Time, Place and Self."

R3's Nurses Notes dated 09/02/14 at 10:00 P.M. document, "Resident up in wheel chair with 1:1 assist today. Alert and oriented X 3."

On 02/04/15 at 8:55 A.M., E1 (Administrator) stated, "(R3) came from (a local nursing facility). They had given (R3) a 30 day discharge notice because of inappropriate behavior. (R3) touched a resident..."

R3's Nurses Notes dated 09/04/14 at 8:20 A.M. document, "Resident in wheelchair in TV (Television) room sitting next to a female resident, (R3) resident reached over and put female's hand on (R3)'s lap. Situation witnessed." 8:30 A.M., "Administrator notified."

On 02/04/15 at 10:00 A.M., when E1

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(Administrator) was interviewed concerning whether the facility investigated or reported the incident to the State Agency, E1 stated, "No we (the facility) did not pursue it, because the Nurse felt it was not inappropriate sexual behavior. No investigation was done nor notification to the (State Agency)."

On 02/04/15 at 10:45 A.M., E4 (Licensed Practical Nurse) stated, "(R3) was admitted two days prior (to 09/04/14) from another nursing home. I knew there had been another allegation of 'touching (at the other facility)', passed on in report to me. I knew there was a potential problem... I seen (R3) touching (R6) and then (R3) placed (R6)'s hand on (R3)'s lap and then I stopped (R3). (R3) is pretty cognizant and so (R3) stopped...Then (R3) took (R6)'s hand and placed it in the center of (R3)'s lap, (R3)'s private area."

On 02/04/15 at 12:20 P.M., E9 (Certified Nursing Assistant) stated, "(R3)'s wheel chair was parked next to a female resident (R6). I seen (R3) grab (R6)'s hand and placed it between (R3)'s legs, (R3)'s private area. I said "We don't do that here' and moved (R3) away from (R6)."

R3's Nurses Notes dated 12/24/14 at 5:15 A.M. document, "Resident sitting in common living room next to female resident. (R3) was seen touching inner thigh of (R5). This nurse stopped (R3) and directed (R3) back to (R3)'s room. An hour later, (R3) was again in common living room seen rubbing the breast of another female resident (R6). (R3) was again stopped and redirected back to (R3)'s room. Administration notified."

The facility's Investigation from the incident on

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12/24/14 includes the following statement from E8 (Licensed Practical Nurse), "At 4:30 A.M., I noticed resident sitting next to (R5) in the living room. (R5) looked upset at (R3). I started walking out there and witnessed (R3) placing (R3)'s hand on (R6)'s inner thigh and rubbing it. (R6) was swatting (R3)'s hand away and saying 'stop it.' I told (R3) to leave (R6) alone and to stop it. What (R3) was doing was inappropriate. (R3) said 'okay' and I helped (R3) back to (R3)'s room. Then about 5:15 A.M., I saw (R3) sitting next to (R6) in the living room and (R3) was rubbing (R6)'s breast over (R6)'s top. I again told (R3) to stop, that (R3) was being inappropriate again. (R3) said 'sorry' and I again walked with (R3) back to (R3)'s room. I then called (E1) Administrator to report these incidents."

On 02/04/15 at 8:55 A.M., E1 (Administrator) stated, "I am not certain that I was notified on the first incident on 12/24/14, where (R3)'s hands were between (R5)'s thighs."

On 02/05/15 at 9:00 A.M., R5 stated, "I remember a man putting his hand in my private area. I didn't feel comfortable and moved his hand away."

The Facility Room Roster, dated 02/03/15 includes the following 40 female residents (R1, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, R20, R21, R22, R23, R24, R25, R26, R27, R28, R29, R30, R31, R32, R33, R34, R35, R36, R37, R38, R39, R40, R41, R42).

(A)

IMPOSED PLAN OF CORRECTION

Aspen Rehab & Healthcare
Complaint survey 1520625/IL74768 – February 11, 2015

300.610a)
300.690b)
300.690c)
300.1210b)
300.3240a)
300.3240d)
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.

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Attachment B
Imposed Plan of Correction

This will be accomplished by:

VI. The facility will investigate incidents and report to the facility Administrator immediately. Allegations will be reported to IDPH. Abuse and Neglect Policy will be reviewed and revised as necessary.

VII. All staff will be in-serviced on Abuse and Neglect Policy and Procedures and any revisions made as a result of Item I.

VIII. All staff will be in-serviced regarding the following:

- Timely reporting and types of abuse and neglect
- Thorough and appropriate investigations
- Appropriate process for background checks
- Identifying residents with potential for being affected by deficient practice (Abuse and Neglect Policy) by review of assessments, interventions, and updating care plans. The facility will reflect condition/behavior changes, follow-up interventions, and reporting practices as appropriate per facility policy
- Monitor for compliance of abuse/neglect investigation and reporting per each occurrence
- Quality Assurance (QA) tools with documentation and monitoring of compliance. All issues and concerns will be corrected immediately and reviewed during the Weekly QA Behavioral Meeting.

IX. Documentation of in-service training will be maintained by the facility.

X. The Regional Director, Administrator, Director of Nursing and Quality Assurance Committee will monitor Items I through V to ensure compliance with this Imposed Plan of Correction.

COMPLETION DATE: Seven (7) days from receipt of this Imposed Plan of Correction.

Attachment B
Imposed Plan of Correction