

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/31/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145222</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/28/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>WOODSTOCK RESIDENCE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>309 MCHENRY AVENUE</b> <b>WOODSTOCK, IL 60098</b>		
(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) COMPLETION DATE	
F 000	INITIAL COMMENTS	F 000			
F 225 SS=D	<p>Incident Report Investigation of 1/6/08, IL # 33053</p> <p>No Extended Survey was conducted.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS</p> <p>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.</p> <p>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).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in</p>	F 225			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	<p>Continued From page 1</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to thoroughly investigate an allegation of rape by not notifying the residents attending physician, not assessing the resident for potential injury, not documenting the allegation in the residents clinical record, not interviewing all staff on all shifts during the period of the allegation, and not interviewing residents who may have had knowledge of the allegation.</p> <p>This applies to 1 resident alleging she was raped on 1/6/08. (R1)</p> <p>The examples include:</p> <p>R1's January, 2008 Physician's Order Sheet documents that R1's diagnoses include Alzheimer's Dementia, Depression, and Anxiety.</p> <p>R1's Minimum Data Set (MDS) assessment of 12/18/08 identified R1 as having a short and long term memory impairment with moderately impaired cognitive skills for daily decision making.</p> <p>E1, Administrator was interviewed on 1/8/08 at 9:00 AM. E1 said that E3 Licensed Practical Nurse (L.P.N.) came to her on Tuesday, 1/8/08</p>	F 225			

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F 225	<p>Continued From page 2</p> <p>and told her that R1 had reported to her that she had been molested on Sunday. E1 said she was not sure if R1's physician had been notified. E1 said that E3 reported this allegation to her verbally.</p> <p>R1's Nursing Notes did not show any documentation on 1/6 or 1/8 regarding an allegation of rape. No physical assessment of R1 was documented after she reported that she had been molested. No documentation concerning notifying R1's physician was in the R1's nursing notes.</p> <p>E2, Director of Nursing , (DON) was interviewed on 1/28/08 at 8:10 AM. E2 said that R1 had reported an incident of rape prior to this. E2 said the first time R1 reported being raped, R1 was sent to the hospital for evaluation. E2 said that R1 came into E1's office and said that while she was asleep, a man came into her room and got in her bed and had sex with her. E2 said I don't know why R1 was not sent out this time for an exam, unless R1 refused.</p> <p>During interview with E1 on 1/28/08 at 9:00 AM, E1 said that R1 had not been sent out for physical evaluation because R1 had taken a shower on Monday, 1/7/08 and the hospital would not be able to perform a rape kit, and that R1 had made this allegation prior and it was unfounded.</p> <p>E1 said that she interviewed E3 and one other staff who worked the night shift on 1/6/08, (E4) E1 said that because she was in the facility on Monday, 1/6/08 she did not think she needed to interview the staff who worked that day shift. E1 said that she had not interviewed any staff from the previous day. (1/5/08).</p>	F 225			

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F 225	<p>Continued From page 3</p> <p>On 1/28/08 at 2:25 PM E2 (DON) was interviewed. E2 said she didn't know why E3 (LPN) did not document the allegation in R1's medical record. E1 said that E3 was not working on R1's unit that day (1/8/08) and she doesn't know why R1 reported being molested to E3. E2 said that E3 was the nurse on the 100/200 unit that day. E1 said E3 should have documented it, "There is no rule that you can not document on someone else's patient." E2 said that there was only one resident on R1's wing that may have been able to be interviewed, (R4). E2 confirmed that R4 had not been interviewed.</p> <p>Review of the facility investigation summary dated 1/8/08 documents when E3 reported the allegation of molestation, E1 and E2 interviewed R1. R1 told E1 and E2 during this interview that she had been raped. R1 did not want to go to the hospital and R1 had already taken a shower. E1 documented in the same report that she notified the police, ombudsman, and R1's Guardian. There was no documentation that R1's physician had been notified. E4 Certified Nursing Assistant (CNA) was interviewed. No other interviews were documented.</p> <p>During interview with E1 and E2 on 1/28/08 at 11:45 PM, E1 said that R1's Guardian suggested giving R1 a room mate. E1 said, "We put a room mate in with R1 so she could tell if someone came in the room." E2 said that R1's current room mate was very confused and would not be reliable.</p>	F 225			

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F 225	<p>Continued From page 4</p> <p>On 1/28/08 at 10:50 Am, R1 was interviewed. R1 said she was having no problems at the facility, but that she did want to go home. R1 said she wants to get out of the facility because "there is nothing wrong with me." R1 could not recall how long she had resided at the facility, or having any problems with being mistreated. R1 said she did not like her room mate, but other than that she was doing ok.</p> <p>Review of the facility policy entitled: Reporting Abuse to Facility Management shows the following:</p> <p>4. When an alleged or suspected case of mistreatment, neglect, injuries of unknown source, or abuse are reported, the facility administrator will notify the following persons or agencies of such incident:</p> <ol style="list-style-type: none"> <li>The State Licensing Agency</li> <li>The local/ state Ombudsman</li> <li>The Resident's Representative</li> <li>Adult Protective Services</li> <li>Law enforcement officials.</li> <li>The resident's attending physician.</li> <li>The Medical Director.</li> </ol> <p>7. (c.) Sexual abuse is defined as, but is not limited to, sexual harassment, sexual coercion, or sexual assault.</p> <p>9. Upon receiving reports of physical or sexual abuse, a licensed nurse or physician shall immediately examine the resident. Findings of the examination must be recorded in the resident's medical record.</p> <p>The policy entitled: Abuse Investigations shows:</p>	F 225			

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F 225	Continued From page 5 3. (f) Interview the resident's attending physician to determine the resident's current mental status.  (g) Interview staff members on all shifts who have had contact with the resident during the period of the alleged incident.  (i) Interview other residents.  The policy entitled: Reporting Suspected Cases and/or Incidents of Rape.  3. (a) Assess the resident for possible injuries.	F 225			