STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145684	A. BUILDING _____ B. WING _____	**06/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MANORCARE OF HOMEWOOD	**940 MAPLE AVENUE HOMEWOOD, IL 60430**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review facility failed to follow their policy on reporting to a state agency regarding an allegation of sexual abuse for two residents (R1, R2) out of three residents reviewed abuse. Findings Include: On 6/6/2020 22:32 R1's General Progress Note reads: Resident was observed in his room with a female resident in the bed under the blankets and naked under the cover. Resident was verbally abusive to the staff and telling them to get the [***] out of the room. Residents family was notified, and Dr. Curtin was notified. On 6/7/2020 00:31 R2' General Progress Note Text reads : At 9:45pm responded to call to go to room of resident #R1. Resident R2 was observed in the room and in bed with male resident without any clothes on under the cover. Instructed resident to place clothes on and leave room redirected her to her room. She refused body assessment and vitals. Resident was angry and refused med's and further treatment. During interview with V3 (Licensed Practical Nurse) at 9:45 am on 6/17/20 , V3 stated she saw R1 on 6/6/20 sitting in the wheelchair by the nurse's station and that approximately half an hour later, was told by staff that R1 and R2 were in bed together. V3 stated walked into R1's room and saw R1 pulling up his pants while he was sitting on the side of the bed and did not see that R1 had an erection. V3 stated she saw R2 under a blanket naked then her and the other supervisor asked R2 to get dressed and come out of R1's room. V3 stated she has never heard of the female residents complaining about R1 trying to persuade them to his room. V3 stated at that time she did not know if sex was consensual. V3 stated they get abuse training annually. V3 stated she had been taking care of R1 for a year and that this was the first time an incident of that nature occurred. V3 stated was she told by another nurse manager to write an incident report and filed it. V3 stated she followed the chain of command and called the supervisor to tell her what had happened. During interview with V4 (Nurse Supervisor) on 6/17/20 at 2:00pm, V4 stated she got the phone call from the nurses on 6/6/20 that R1 and R2 were found lying in the bed naked. V4 stated staff explained to her that R1 and R2 were upset being interrupted having sex. V4 stated she called DON, administrator and told them what had happened and was going to the facility. V4 stated was told by the administrator and DON to do an investigation. V4 stated she gathered the aides, nurses and got a statement from the residents (R1, R2). V4 stated she asked R1 what had happened and that R1 and R2 were having a conversation and that she wanted to come back to his room. V4 stated once in his room they got in the bed and he went in the bathroom. V4 stated R1 told her that he got in the bed and was getting ready to have sex, but people came in his room. V4 stated she talked to R2 and R2 said was in a mans room and she said they were going to have sex and that is my business. V4 stated she asked R2 did they have sex and she replied, No they came in there. V4 stated she instructed staff to notify R1 and R2 family/doctor about what had happened. V4 stated she then spoke to Administrator and Don about the conclusion of her investigation which was a couple hours later. V4 stated not reporting the incident to the state (IDPH) before it was concluded what had happened was up to the administrator. During interview with V2 (Director of Nursing) on 6/17/20 at 2:30pm V2 stated she was called by Nurse Manager (V4) that two residents were discovered in the bed together. V2 stated at that time when she got the call she did not know if the two residents (R1, R2) had consented to have sex with each other. V2 stated if they don't know if sex is consensual, I should investigate. V2 stated the abuse policy guides them to investigate and does dictate to inform IDPH. During interview with V1 (Administrator) on 6/17/20 at 3:00pm V1 stated residents have rights to have sex if it is consensual. V1 stated they did their investigation of what had happened on 6/6/20 and concluded in less than two hours that R1 and R2 tried to have consensual sex. V1 stated spoke to his company and they felt it was nothing to report to IDPH because there was no abuse or forced sex or exploitation taking place. V1 stated he did not know at the beginning of being told of R1 and R2 lying in bed that it was consensual but found very shortly later. V1 stated should not have to report to IDPH about sex that is consensual even though it was not determined right away it was consensual. Facility's abuse policy denotes in accordance with federal guidelines, it is the duty to report any suspicion of crime against a resident who resides in a skilled nursing center. This includes mistreatment, neglect, verbal, mental, sexual and physical abuse, injuries of unknown source, and misappropriation of patient property. Definition sexual abuse is non-consensual sexual contact of any type. The report must be made to local law enforcement and the state survey agency. Reporting the allegation of abuse: Ensure that all alleged violations involving abuse are reported immediately but not later than 2 hours after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury, or not later that 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other official including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities in accordance with State law through established procedures.

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