STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145668	A. BUILDING _____ B. WING _____	C 03/02/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN HOME, THE	**150 NORTH 27TH STREET BELLEVILLE, IL 62226**

(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 Complaint investigation #0940917/IL40063 Not an extended survey.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS 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. 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). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State	F 225		

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

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F 225	Continued From page 1 survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to thoroughly investigate and report an allegation of resident sexual abuse, perpetrated by a visitor, for one resident on the sample, R1. Findings include: During an interview with E1 (Acting Administrator and Director of Nursing) on 2/26/09, it was stated that some of the staff thought that on Sunday, 2/22/09, R1's family member was touching her inappropriately. E1 said that upon questioning, R1 vehemently denied that anything occurred so, the facility did not investigate the allegation any further. E1 said that the facility did not notify R1's physician, report the incident to the Department or contact local law enforcement. During an interview with E4 (Certified Nurses Aide-CNA) on 2/26/09, it was stated that on 2/22/09, at approximately 12:30 PM, another CNA told her to keep an eye on R1 and Z1 (R1's visitor). E4 said that there has been rumors that Z1 may be sexually inappropriate with R1. E4 could not recall who said that Z1 may be sexually inappropriate or when it was said. E4 said that R1 was sitting in the television area when Z1 arrived. Z1 then wheeled R1 to her room. Several moments later, E4 entered R1's room through the adjoining bathroom. E4 said that when she	F 225		

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F 225	Continued From page 2 entered R1's room, she saw Z1's hand down the front of R1's pants. He was moving his hand up and down near R1's pubic area. E4 said that she immediately exited R1's room and went and got the nurse. E4 stated that E3 (LPN) came down to R1's room and asked Z1 to leave the building. E4 said that she accompanied E3 when she walked down to R1's room to asked Z1 to leave. Z1 was walking out of R1's room, wiping his hand on a handkerchief. E4 said that Z1 left the building without any problem. During an interview with E3, on 2/26/09, it was stated that E3 had heard rumors regarding Z1's behavior towards R1. E3 said that "I heard it happened before, so I kept my eye on Z1". E3 could not recall who she heard the rumor from or when she had heard it. E3 said that she was busy passing medications when Z1 came into the facility on 2/22/09. E3 told E4 to keep an eye on Z1 when E3 saw Z1 take R1 out of the television viewing area to R1's room. E3 said that E4 witnessed Z1 fondling R1 so he was asked to leave the building. Z1 asked E3 why he had to leave the building. E3 told Z1 that inappropriate behavior was observed. E3 said that Z1 never said a word, He just walked out. E3 said that after Z1 left the building, she went and talked to R1. R1 denied that anything inappropriate happened. She said that Z1 was rubbing her leg. According to E3, no one physically examined R1. E3 said "Z1 must have known that we knew. He was wiping his hands on a white handkerchief which he put in his pocket and walked out." Z1 called E3 about an hour later and asked when he could come in and visit R1 again. E3 told Z1 that it was out of her hands. E3 said that she immediately reported the incident to the supervisor on-call for the day, E2 (Assistant Director of Nursing).	F 225		

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F 225	Continued From page 3 During an interview with E2 on 2/26/09, it was stated that E3 called E2 at home during the early afternoon on 2/22/09 about the situation with R1. E3 said that Z1 was in R1's room with the lights off and his hand in R1's pants. E2 told E3 to make sure that Z1 left the facility. No physical exam was performed on R1. E1 and E2 began an investigation into the incident on Monday, 2/23/09. E2 said that since R1 denied that anything inappropriate occurred, the investigation was stopped. E2 said that they did have statements from staff who witnessed the incident. The facility failed to follow it's own policy entitled Abuse Prevention. The facility failed to report and investigate rumors heard months before 2/22/09, regarding Z1's inappropriate behavior towards R1. The facility failed to assess R1 and develop a care plan to prevent further potential abuse from occurring. The facility failed to thoroughly investigate the incident and notify the proper authorities (local law enforcement and the Department).	F 225		
F 492 SS=C	483.75(b) ADMINISTRATION The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on interview, observation and record review, the facility fails to have an Administrator licensed by the State of Illinois.	F 492		

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F 492	Continued From page 4 Findings include: Throughout all days of the survey, from 2/26-3/2/09, it was noted that E1 (Acting Administrator and Director of Nursing) was functioning as the Director of Nursing. E9 (Marketing Director) had been the previous Administrator but, had not been able to obtain reciprocity for his out-of-state Administrator's License. During interviews with E1 on 3/2/09, it was stated that E6 is the current Director of Nursing in the Facility. E1 said that she has applied for her temporary Administrators License. During an interview with E6, on 3/2/09, it was stated that E6 was hired to be a Minimum Data Set and Restorative nurse. E6 said that she does "other duties as assigned". E6 was asked if she is the Director of Nursing in the Facility. E6 said "No". E6 was asked if she is getting paid as the Director of Nursing. E6 stated "No". During interviews with E5, E7 and E8, all LPN's working in the facility, all stated when asked who the Director of Nursing is in the facility, "E1". When asked who the Administrator in the facility is, all stated "E9".	F 492		