STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003388	A. BUILDING: _____ B. WING _____	04/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP MANOR	1209 21ST AVENUE ROCK ISLAND, IL 61201

(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 Annual Licensure and Re-Certification Survey. Federal Oversight and Support Survey. An extended survey was conducted.	S 000		
S9999	Final Observations Statement of Licensure Violations : 300.610a) 300.690a)b)c) 300.1210b) 300.3240a)b)d)e) 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 a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident.	S9999	Attachment A Statement of Licensure Violations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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FRIENDSHIP MANOR	1209 21ST AVENUE ROCK ISLAND, IL 61201

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S9999	Continued From page 1	S9999		

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 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)
b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003388	A. BUILDING: _____ B. WING _____	04/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP MANOR	1209 21ST AVENUE ROCK ISLAND, IL 61201

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S9999	Continued From page 2	S9999		

immediately report the matter to the facility administrator. (Section 3-610 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)
e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee.

These requirements are not met as evidenced by:

Based on observation, record review and interview, the facility failed to protect one resident from emotional abuse. E4 and E5 wore R2's wig in front of R2 laughing and making fun of R2 which caused emotional upset and embarrassment for R2 which continues. The facility also failed to protect one resident from sexual abuse. E9 inappropriately touched R24 on one occasion (1/5/16) and continued to have access to R24 when E9 made a sexually inappropriate comment to R24 approximately one week later (1/13/16). R2 and R24 were two of three residents reviewed for allegations of abuse in the supplemental sample. E4, E5 and E9 had continued access to all residents in the facility. Additionally, the facility failed to immediately report an allegation of abuse to the Administrator; failed to recognize sexual abuse, emotional abuse and misappropriation of resident property; failed to thoroughly investigate an abuse allegation; failed to immediately remove alleged

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003388	A. BUILDING: _____ B. WING _____	04/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP MANOR	1209 21ST AVENUE ROCK ISLAND, IL 61201

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S9999	Continued From page 3	S9999		

perpetrators from resident contact; failed to follow operational policies and procedures regarding: Immediate notification to the Abuse Coordinator and Administrator; identification of misappropriation of resident property, sexual abuse and mental abuse; and protection of the resident by the removal of the suspected perpetrator of abuse.

Findings include:

The undated facility's Quality of Life - Dignity policy documents the following: "Residents shall be treated with dignity...Residents' private space and property shall be respected at all times...Staff will not handle or move a resident's personal belongings without the resident's permission..."

1. R2's Minimum Data Set (dated 1/31/16) documents a Brief Interview for Mental Status score of 11, indicating R2 is a reliable candidate for an interview.

1. R2's Minimum Data Set (dated 1/31/16) documents a Brief Interview for Mental Status score of 11, indicating R2 is a reliable candidate for an interview.

R2's initial Incident Report dated 12/15/15 and completed by E8 (Assistant Director of Nursing/Acting Abuse Coordinator) documents that the facility initiated an investigation on 12/15/15 for an allegation of " emotional abuse " involving R2.

The facility's faxed initial report dated 12/15/15 and completed by E8 (Assistant Director of Nursing/Acting Abuse Coordinator) to (State

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003388	A. BUILDING: _____ B. WING _____	04/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP MANOR	1209 21ST AVENUE ROCK ISLAND, IL 61201

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S9999	Continued From page 4	S9999		

Agency) documents the following: "This is to report an allegation of abuse of a resident's belongings. A CNA was reportedly wearing (R2)'s wig. (R2) has some confusion and a diagnosis of Dementia..."

The facility's faxed final investigation report dated 12/18/15 and completed by E8 to (State Agency) documents the following: "This follow-up is in regards to the previously reported allegation of abuse. A full investigation was conducted in which two employees, (E4 and E5, Certified Nursing Assistants) were interviewed; (R2) was interviewed twice and (R25, R2's roommate) was also interviewed. During the interviews, both E4 and E5 admitted (R2) was upset because the (E4 and E5) were washing (R2's) wig which had ice cream on it. The date of the incident, per (E4 and E5) was 12/10/15. After interviewing (E4 and E5) and (R2), it is difficult to determine whether there was abuse of (R2's) belongings. (R2) continues to report that (E4 and E5) were wearing (R2)'s wig and it was upsetting to (R2). (E4 and E5) maintain (R2) spilled ice cream and they (E4 and E5) were simply cleaning it. Although (R2) does have a diagnosis of dementia, (R2) was able to identify (E4 and E5) that (R2) felt were wearing (R2)'s wig. We (the facility) cannot conclude abuse was substantiated; however, we (the facility) will terminate employment of (E4 and E5) to protect our residents in case this situation did occur."

On 4/7/16 at 1:15 PM, E8 (Assistant Director of Nursing/Acting Abuse Coordinator) stated, "It was brought to my attention that two CNA ' s (Certified Nursing Assistants) were in (R2)'s room, put (R2)'s wig on and was dancing around. This upset (R2). I think E6 (Licensed Practical Nurse)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003388	A. BUILDING: _____ B. WING _____	04/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP MANOR	1209 21ST AVENUE ROCK ISLAND, IL 61201

(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	Continued From page 5	S9999		

told me (E8). E6 usually works second shift. I think E6 told me face-to-face. I (E8) became aware of the incident on 12/15/15. I (E8) reported to (E1, Administrator) on 12/15/15... ". E8 then stated that E4 and E5 were not removed from resident care until 12/15/15 following the 12/13/15 incident with R2.

The CNA's were (E4 and E5). On 12/15/15, I (E8) met with (E5) and (E5) was taken off of the schedule. I (E8) met with (E4) on 12/16/15. (E4) couldn't come in on 12/15/15. I (E8) reported to (E1, Administrator) on 12/15/15...We terminated both CNA's (E4 and E5)."

On 4/7/16 at 2:20 p.m., E6 (Licensed Practical Nurse) stated that on 12/10/15 (E6) saw a picture of (E4 and E5) wearing wigs on a (Social Media Picture Website). E6 stated, "The picture only lasts a few seconds. I (E6) saw (E4 and E5) with wigs on (E4 and E5)'s heads in a picture. I (E6) tried to take a screen shot of it, but it only lasts a short time and it (the picture) was already gone. I (E6) couldn't tell where they were just that they (E4 and E5) were wearing wigs. The next day, (R2) complained to (E21, former Certified Nursing Assistant). E21 went and got E7 (Licensed Practical Nurse) and (E7) came and told me (E6). It was approximately 8:00 p.m. (E7) said (R2) told (E7) about it. I (E6) told (E7) I (E6) would report it. I (E6) reported it immediately to (E8, Assistant Director of Nursing/Acting Abuse Coordinator) by phone. The night (12/11/15) that I (E6) called (E8), (E4 and E5) were both working. I (E6) called (E8) and left a message. (E8) didn't call back. (E8) called me (E6) the Monday (12/14/15) after the weekend. I (E6) want to say that I saw the picture on a (Social Medial Picture Website) on 12/10/15, heard about and reported (R2's) complaint to (E8) on 12/11/15, and spoke to (E8) about it on 12/14/15. (E4 and E5,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003388	A. BUILDING: _____ B. WING _____	04/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP MANOR	1209 21ST AVENUE ROCK ISLAND, IL 61201

(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	Continued From page 6	S9999		

Certified Nursing Assistants) were smiling in the picture thinking they (E4 and E5) were funny..." ..." E6 then stated that E6 did not immediately report R2's concern to E1 (Administrator).

On 4/11/16 at 12:09 PM, E7 (Licensed Practical Nurse) stated that E7 usually works third shift, but worked a second shift on 12/11/15. E7 then stated that on 12/11/15 at approximately 7:00 PM, (R2) become upset after a (E21, former Certified Nursing Assistant) attempted to give (R2) a shower. E7 stated, "(R2) was hysterical. (R2) was trying to kick (E21) out of the room. (R2) thought that (E21) was one of the CNA's (Certified Nursing Assistants) that was wearing (R2's) wigs (on 12/10/15). I (E7) talked to (R2) and calmed (R2) down and then (R2) allowed (E21) to care for (R2). I (E7) went and told (E6) what (R2) had told me and (E6) said 'Wow it really happened.' (E6) said to me (E7) that (E6) had seen a picture of (E4 and E5) last night (12/10/15) posted on a (Social Media Picture Website) and (E4 and E5) were wearing wigs. (E4 and E5) were both working on 12/11/15. (E6) called (E8, Assistant Director of Nursing/Acting Abuse Coordinator) and left a message. (E4 and E5) worked the rest of their (E4 and E5)'s shifts on 12/11/15. (R2) continued talking about this for a couple weeks. (R2) would become upset about something, but it seemed that the root of the problem always went back to (E4 and E5) wearing (R2)'s wigs. (R2) was extremely upset. (R2) felt degraded and (R2) felt that (E4 and E5) were making fun of and laughing at (R2)."

R2's written interview dated 12/16/15 and signed by (E8) and (E15, Social Service Director) documents the following: "Two girls got real fresh with me the other night. They had my wig in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003388	A. BUILDING: _____ B. WING _____	04/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP MANOR	1209 21ST AVENUE ROCK ISLAND, IL 61201

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S9999	Continued From page 7	S9999		

bathroom and they were posing in the mirror with it on. One was overweight, wearing all black and the other was small. She had black hair and was working the next night. Everything they said was hurtful. I don't think I went to supper. I had ice cream as a snack. The small one was really brazen and paraded around my bed, she grabbed the wig and I asked her to put it on the stand but she went into the bathroom and was posing in the mirror." R2 then denied spilling anything on R2's wig and stated, "They were laughing a lot. They were dancing around with my wig on. Making fun of me. Why are you asking me so many questions. You don't care. You don't care! I didn't spill anything on my wig, they were making fun of me!"

On 4/11/16 at 12:05 PM, R2 was lying in R2's bed. R2's hair was extremely thin and disheveled exposing several areas of R2 ' s scalp. R2's wigs were located and neatly kept on a shelf next to R2's bed. R2 stated, " I (R2) do not want to repeat it. I prefer them (E4 and E5) not take care of me ever again. They were very ... (R2 unable to finish statement) when asked about the 12/10/15 incident involving E4 and E5. R2 appeared very withdrawn and avoided eye contact continually staring at the floor. R2 immediately changed the subject of the conversation and stated that R2 was waiting for a meal tray. Upon further discussion and subsequent mention of the 12/10/15 incident, R2 stated, " I (R2) hate this place." When R2 was asked how E4 and E5 (Certified Nursing Assistants) made R2 feel when E4 and E5 were wearing R2's wigs on 12/10/15, R2 again stared at the floor and avoided eye contact, sat in silence for approximately one minute and with a flat affect did not answer the question and stated, "You can go anytime now. "

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	IL6003388	A. BUILDING: _____ B. WING _____	04/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP MANOR	1209 21ST AVENUE ROCK ISLAND, IL 61201

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S9999	Continued From page 8	S9999		

R2's full final Abuse Investigation (dated 12/18/15) does not include witness interviews or written statements from E21, E6 or E7. On 4/11/16 at 10:49 AM, E8 (Assistant Director of Nursing/ Acting Abuse Coordinator) verified that E8 could not produce written witness statements or interviews from E21, E6 or E7 regarding R2's verbalized concerns on 12/11/15 and stated that E8 only documented one of the two interviews conducted with R2 because E8 did not have a staff member to witness the second interview.

On 4/12/16 at 10:07 AM, E8 stated that emotional abuse is any kind of statement made that is taken offensively by the resident or makes them upset. Misappropriation of resident ' s property is stealing from the residents or taking the resident ' s funds. E8 then stated that E8 considered E4 and E5 ' s behavior inappropriate on both parts of E4 and E5. E8 then stated that R2 gave R2 ' s statement and there was no witness to the 12/10/15 incident. E8 also stated when asked if E8 considered the 12/10/15 incident regarding R2 abuse, " No. I don ' t consider it abuse. I consider it stupidity. Unfortunately, there was no witness. If (E4 and E5) were indeed wearing (R2) ' s wigs, I (E8) would consider it misappropriation of property, but there is no proof of it. "

On 4/7/16 at 12:48 PM, E2 (Director of Nursing) stated that E2 was off at the time of R2 ' s complaint regarding (E4 and E5) ' s wearing R2 ' s wigs, and the investigation was conducted by E8 (Assistant Director of Nursing/Acting Abuse Coordinator). E2 stated that any resident complaint about an employee is looked into and that all staff are expected to immediately report any potential allegations of abuse. E2 stated, "I (E2) interviewed both (E4 and E5) over the phone

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003388	A. BUILDING: _____ B. WING _____	04/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP MANOR	1209 21ST AVENUE ROCK ISLAND, IL 61201

(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	Continued From page 9	S9999		

and we (the facility) fired them because their (E4 and E5) ' s stories did not match what was on camera."

E4 and E5 ' s Employee Detail Report Time Cards (dated 12/1/15- 12/31/15) document that both E4 and E5 worked full eight hour shifts on 12/10/15, 12/11/15 and 12/14/15 thus allowing E4 and E5 continued access to R2 after E6 (Licensed Practical Nurse) recognized and reported an allegation of emotional abuse and misappropriation of R2 ' s property on 12/11/15.

2. R24's Initial Incident Report dated 1/15/16 documents that an abuse investigation was initiated on 1/15/16 regarding an allegation of an "inappropriate comment" made on 1/13/16 to R24 by E9 (Former Certified Nursing Assistant).

E10 ' s (former Certified Nursing Assistant) written statement dated 1/13/16 at 8:30 PM documents the following: "While myself (E10) and (E9) were in (R24) ' s room cleaning (R24) up for bed, (E9) leaned (E9) ' s head around to look at (R24) and said, 'Am I (E9) getting you riled up?' After (E9) left the room, (R24) stated (to E10) that (R24) is very uncomfortable with (E9) working with (R24) because of what (E9) says and (E9) touches (R24)."

On 4/6/16 at 1:10 p.m., E10 verified the above written statement and stated, "Sometimes when you ' re wiping a male in that area, blood begins to flow and they can't help it (getting an erection). " E10 indicated that R24 began to get an erection when E9 was cleaning R24 ' s peri-anal area. E10 then stated, " The incident occurred sometime before dinner on 1/13/16. 8:30 PM is the time I

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003388	A. BUILDING: _____ B. WING _____	04/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP MANOR	1209 21ST AVENUE ROCK ISLAND, IL 61201

(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	Continued From page 10	S9999		

(E10) sat down on 1/13/16 and wrote out the statement. After it occurred, I (E10) called the (E11, Licensed Practical Nurse) into (R24) ' s room. That's not the first time something like this has happened. (R24) and others reported previous concerns to (E12, Licensed Practical Nurse). (E12) went to (E8, Assistant Director of Nursing/Acting Abuse Coordinator) multiple times over this. (E12) refused to have (E9) work (R24) ' s floor. When (E11) was in the room on 1/13/16, I told (E11) what I (E10) had witnessed. (E11) asked (R24) how (R24) felt and (R24) said that (R24) didn ' t want (E9) back in the room at all." E10 then stated that E10 felt E9 ' s comment was indeed, "Abusive in nature because the way (E9) said it and the look on (E9) ' s face. It was degrading to (R24)." E10 then stated that E10 did not report the incident to E2 (Director of Nursing/Abuse Coordinator) or E1 (Administrator) because E10 had reported it to E11 on 1/13/16 and E12 on the afternoon of 1/14/16. E10 also stated that E10 called the facility on the morning of 1/14/16 and reported the incident to E8 (Assistant Director of Nursing/Acting Abuse Coordinator) because E2 was off and E8 was acting as the Abuse Coordinator. E10 also stated that E9 continued to work until the end of E9 ' s shift on 1/13/16.

E12 ' s (Licensed Practical Nurse) written statement dated 1/15/16 documents the following: "On 1/14/16, (R24) was sitting by the nurse's station and stated that (E9) was inappropriate with (R24) again last night. (E12) asked (R24) what happened and (R24) said (R24) was being cleaned up by (E9, Former Certified Nursing Assistant) and (E10, Former Certified Nursing Assistant) was assisting (E9) and (E10) was standing by (R24) as (R24) was telling (E12) that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003388	A. BUILDING: _____ B. WING _____	04/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP MANOR	1209 21ST AVENUE ROCK ISLAND, IL 61201

(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	Continued From page 11	S9999		

when (E9) was wiping (R24), (E9) asked (R24) if that felt good or excited (R24) [I (E12) couldn't remember which term] but (R24) stated it made (R24) feel uncomfortable. Writer (E12) reported this to (E8) today 1/15/16. "

On 4/6/16 at 12:20 PM, E12 verified the above written statement and stated that E12 was not working when the incident involving E9 and R24 occurred on 1/13/16. E12 stated that E12 did not report the above incident to anyone on 1/14/16 because R24 did not want E12 to say anything and stated, "I (E12) should have called that day (1/14/16). What (R24) told me (E12) that (E9) said was abusive in nature. I reported it to (E8, Assistant Director of Nursing/Acting Abuse Coordinator) on 1/15/16 in the morning. " (E12) then stated, " Sexual abuse is any inappropriate touching from anyone or verbally inappropriate sexual comments and verbal abuse is any comment made that is inappropriate or makes someone feel sad or upset or uncomfortable." E12 also stated that all allegations of abuse are to immediately be reported to E2 (Director of Nursing/Abuse Coordinator). E12 made no mention of the need to immediately notify E1 (Administrator) of any allegation of abuse.

On 4/7/16 at 9:52 AM, E12 stated, "There was one other occasion when (R24) mentioned that (E9) had made (R24) feel uncomfortable. It was about a week before (R24) told (E12) about the comment that (E9) made on 1/13/16. (R24) said that (E9) rubbed (R24) ' s back and it made (R24) feel uncomfortable. (E12) asked (R24) why and (R24) said (R24) had (R24)'s shirt off at the time (E9) started rubbing (R24) and (R24) didn ' t want (E9) back in (R24) ' s room. (E12) reported this to (E8) in morning report right after (R24)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003388	A. BUILDING: _____ B. WING _____	04/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP MANOR	1209 21ST AVENUE ROCK ISLAND, IL 61201

(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	Continued From page 12	S9999		

reported the incident to (E12). The care plan team meets together every morning. (E12) told (E8) when (E8) came to get daily updates. After the morning meeting, (E12) went into the office with (E8) and discussed it further. (E9) was just different. I (E12) can see why people felt uncomfortable. I (E12) even felt uncomfortable with (E9)..."
At this same date and time, E12 then stated that E12 was first aware of the 1/13/16 incident on 1/14/16 around 2:00 PM when R24 told E12 with E10 (Former Certified Nursing Assistant) standing next to R24. E12 then stated, "(R24) is pretty easy going. It was out of character for (R24) to complain about someone. (E10) told me (E12) that (E10) told the nurse that was working the night before." E12 stated that the first incident regarding the touching occurred on 1/5/16 and E9 didn't work a set area but floated and worked all areas of the building. E12 then stated that R24 looked shocked when R24 told E12 about the 1/13/16 incident and, "(R24) was upset. (R24) may have been trying to mask it because (R24) was in the Army and is not an overly emotional person. If it happened to me (E12) or my parents, I (E12) would be really upset. (R24) possibly could be humiliated or embarrassed from a comment like that."

E11 ' s (Licensed Practical Nurse), undated written statement documents the following: "On 1/14/16, (R24) stated that (E9) made an inappropriate comment about getting (R24) riled up while (E9) was cleaning (R24) ' s backside. (R24) stated that (R24) was uncomfortable with (E9) giving (R24) cares. I reported this to (E8, Assistant Director of Nursing/Acting Abuse Coordinator) on 1/15/16."
On 4/6/16 at 12:15 p.m., E11 stated that R24 told E11 that R24 was uncomfortable with E9

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003388	A. BUILDING: _____ B. WING _____	04/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP MANOR	1209 21ST AVENUE ROCK ISLAND, IL 61201

(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	Continued From page 13	S9999		

providing care to R24. E11 stated that E11 reported this to E2 (Director of Nursing/Abuse Coordinator) or E8 and E9 was told to go home the day E11 reported R24 ' s concerns. E11 also stated that any allegation of abuse is reported to E2 or E8. E11 was unaware that E1 should be immediately notified of any allegation of abuse.

On 4/6/16 at 11:45 a.m., R24 stated that E9 (Former Certified Nursing Assistant) made a remark to R24 on 1/13/16 that, "Made me (R24) very uncomfortable." R24 then stated that E9 would, "Rub (E9) ' s hands on my shoulders and it made me (R24) feel uncomfortable. It takes a lot to make me (R24) feel very uncomfortable. If a man did that to a woman, then he would be in big trouble ... I (R24) did not want (E9) touching me like (E9) was. It was more inappropriate than friendly. I (R24) let it go by for a while, a few weeks, before I (R24) said anything."

On 4/7/16 at 11:45 a.m., R24 stated that when E9 touched and rubbed R24 ' s shoulders, it, "Creeped me (R24) out. I (R24) do not like (E9)." R24 then stated that the comment E9 made to R24 on 1/13/16, "Surprised me (R24). I (R24) was uncomfortable and upset and wanted it addressed." R24 then stated that R24 prefers to no longer discuss the 1/13/16 incident.

On 4/6/16 at 1:39 PM, E1 (Administrator) stated that E1 was first notified of any concerns from R24 by a text message from E8 on 1/15/16. E1 provided a copy of the text message dated 1/15/16 and timed 3:17 p.m. which documents the following by E8: "Nursing staff member (E9) is being taken off the schedule per (E8). (E9) was helping clean (R24) and made sexually inappropriate comments about him getting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003388	A. BUILDING: _____ B. WING _____	04/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP MANOR	1209 21ST AVENUE ROCK ISLAND, IL 61201

(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	Continued From page 14	S9999		

aroused. (E8) is making report."

On 4/6/16 at 2:50 PM, E8 (Assistant Director of Nursing/Acting Abuse Coordinator) stated that E8 was Acting Abuse Coordinator at the time of R24 ' s verbalized concern on 1/13/16. E8 stated that E8 was notified of R24 ' s concerns from 1/13/16 by E12 (Licensed Practical Nurse) on 1/15/16. E8 then stated, "(E12) stated that (R24) had expressed feelings that (E9) made comments that made (R24) feel uncomfortable. (E10) was in the room at the time and witnessed the comment. The incident occurred on 1/13/16. I think staff was unsure if it was an actual abuse thing. They (the staff) thought it was inappropriate. I (E8) feel that it was something that would be reportable. It's not right. I (E8) would expect to be immediately notified of an allegation of abuse. When (the 1/13/16) incident was reported, I (E8) recognized it as a potential allegation of abuse...I (E8) know (R24) said (E9) touched (R24) ' s shoulder. (E9) was a little slower..." E8 also stated that sexual abuse is, "A suggestive statement made to a resident by a CNA (Certified Nursing Assistant) or Nurse or inappropriate touching."

On 4/7/16 at 11:04 AM, E8 stated that something was brought to E8 ' s attention approximately a week to a week and a half before the 1/13/16 incident involving R24 and E9 by E12. E8 stated that R24 said R24 was uncomfortable after E9 gave R24 a back rub. E8 stated no report or investigation was conducted at that time and E8 did not speak to R24 about R24 ' s complaint. E8 then stated, "I think it (E9 ' s comment to R24 on 1/13/16) was inappropriate...The only thing (R24) has ever complained about is (E9). I (E8) investigated it (1/13/16 incident) because it is protocol. (R24) made the complaint and when it

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003388	A. BUILDING: _____ B. WING _____	04/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP MANOR	1209 21ST AVENUE ROCK ISLAND, IL 61201

(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	Continued From page 15	S9999		

was brought to my (E8) attention, I (E8) investigated. I (E8) investigate all complaints." E8 then stated that there was no investigation or follow up to the first incident regarding (R24) and (E9) because, "A back rub is part of HS (bedtime) cares. It's standard of care. CNA's (Certified Nursing Assistant) do that."

E9 ' s Final Employee Detail Report Time Card (dated 1/1/16- 1/31/16) indicates that E9 worked an entire eight hour shift on 1/13/16.

E9 ' s signed Performance Correction Notice dated 1/20/16 documents the following: "You made an inappropriate comment to a resident while caring for him. The resident was in a compromising position, as you were providing personal care to his private area. You stated to the resident while cleansing him 'does this get you riled up?' This is inappropriate and made the resident feel uncomfortable. While this may not constitute direct abuse, this is considered borderline both physically and verbally. The resident is not confused and is a reliable source. This is a violation of the harassment policy as well. Your employment at (the facility) is terminated."

On 4/7/16 at 12:48 PM, E2 (Director of Nursing) stated if a resident complains about an employee, it's looked in to. E2 stated E2 was off at the time of the 1/15/16 investigation involving R24 and E9 but was kept informed by E8, who conducted the investigation. E2 then stated, " If (R24) complains to a staff member about back rubs making (R24) uncomfortable, then it should be reported to (E2) or (E8) and we would follow up. If staff receives a complaint about the same employee a second time, I (E2) expect them to immediately report to (E2) or (E8)..." E2 then

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003388	A. BUILDING: _____ B. WING _____	04/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP MANOR	1209 21ST AVENUE ROCK ISLAND, IL 61201

(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	Continued From page 16 stated regarding the 1/13/16 incident involving R24 and E9, "If they (staff) didn't report it immediately, they (staff) didn't consider it abuse. It was a stupid comment. It was no way sexual abuse. It was a dumb statement. I don't consider the comment (E9) made sexual abuse or sexual harassment." 3. R100 ' s Initial Incident Report (dated 10/1/15) documents an allegation of verbal abuse involving R100 was initiated on 10/1/15. R100 ' s timeline of R100 ' s 10/1/15 abuse investigation documents the following: " Notified (E1, Administrator). " This same report does not document the date or time that E1 was notified of R100 ' s allegation of abuse. On 4/11/16 at 10:36 AM, E2 (Director of Nursing) stated that E2 could not provide any documentation of the time that E1 was notified of R100 ' s allegation of abuse. On 4/11/16 at 3:30 PM, E2 stated that Certified Nursing Assistants typically get assigned to the same hallway for continuity but can get floated to another hall at any time to fill staffing needs or assist. On 4/11/16 at 3:30 PM, E2 stated that Certified Nursing Assistants typically get assigned to the same hallway for continuity but can get floated to another hall at any time to fill staffing needs or assist. The Resident Census and Conditions of Residents form (Centers for Medicare and Medicaid Services- Form 672) dated 4/4/16 and completed by E2 (Director of Nursing) indicates 78 residents currently reside in the facility.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003388	A. BUILDING: _____ B. WING _____	04/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP MANOR	1209 21ST AVENUE ROCK ISLAND, IL 61201

(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	Continued From page 17	S9999		

On 4/11/16 at 10:36 AM, E2 stated that E2 could not provide documentation that E1 (Administrator) was immediately notified of the above abuse allegation verbalized by R2 on 12/11/15.

The facility ' s Abuse Investigation policy (revised 1/2015) documents the following: " All reports of resident abuse, neglect and injuries of unknown source, crime or mistreatment shall be promptly and thoroughly investigated by facility management ... An incident or suspected incident of resident abuse, mistreatment, neglect, crime or injury of unknown source will be immediately reported to the Abuse Coordinator and/or designee and Administrator ... The individual conducting the investigation will ... Interview the person(s) reporting the incident, Interview any witnesses to the incident, interview the resident (as medically appropriate), interview staff members (on all shifts) who may have had contact with the resident during the period of alleged incident and interview other residents to whom the accused employee provides care or services ... Witness reports will be reduced to writing. Witnesses will be required to sign and date such reports ... Employees of this facility who have been accused of resident abuse will be suspended from duty until the results of the investigation have been reviewed by the Administrator ... "
The facility ' s undated Abuse and Neglect Prevention policy documents the following: " (The facility) will not tolerate abuse and neglect by any individual including staff, family, volunteer or consultant ...Abuse means any act that willfully injures a resident at (the facility) including unreasonable isolation, intimidation, or punishment of a resident. Physical abuse may

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003388	A. BUILDING: _____ B. WING _____	04/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP MANOR	1209 21ST AVENUE ROCK ISLAND, IL 61201

(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	Continued From page 18 include hitting, kicking, pinching ... or inappropriate sexual language or conduct. Verbal abuse includes the use of words, signs or gestures to intimidate, demean, curse, harass, or threaten harm to the resident ... Abuse may also include the misuse of the resident ' s funds or the misappropriation of resident ' s property. Misappropriation of resident property means using a resident ' s cash, clothing or other possessions without authorization by the resident or the resident ' s legal agent ... " The facility ' s Employee Handbook (dated 2/1/16) documents the following: " Harassing conduct includes but is not limited to: epithets, slurs or negative stereotyping; threatening, intimidating or hostile acts; denigrating jokes ... Sexual Harassment, according to the Illinois Human Rights Act, Sexual Harassment is defined as: ' Any unwelcome sexual advances, requests for sexual favors or any conduct of a sexual nature ... " (B) 300.1210b) 300.1220b)3)7) 300.3240a) 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.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003388	A. BUILDING: _____ B. WING _____	04/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP MANOR	1209 21ST AVENUE ROCK ISLAND, IL 61201

(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	Continued From page 19 Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months 7) Coordinating the care and services provided to residents in the nursing facility. 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) These requirements are not met as evidenced by: Based on interview, observation and record review, the facility failed to ensure that follow up was provided to a resident after episodes of abuse occurred for two of three residents (R2 and R24) reviewed for abuse allegations on the supplemental sample. E4 and E5 wore R2's wig in front of R2 laughing and making fun of R2,which caused emotional upset and embarrassment for R2 which continues. Findings include: 1. R2's Minimum Data Set (dated 1/31/16) documents a Brief Interview for Mental Status	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003388	A. BUILDING: _____ B. WING _____	04/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP MANOR	1209 21ST AVENUE ROCK ISLAND, IL 61201

(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	Continued From page 20	S9999		

score of 11, indicating R2 is a reliable candidate for an interview.

R2's initial Incident Report dated 12/15/15 and completed by E8 (Assistant Director of Nursing/Acting Abuse Coordinator) documents that the facility initiated an investigation on 12/15/15 for an allegation of "emotional abuse" involving R2.

The facility's faxed initial report dated 12/15/15 and completed by E8 (Assistant Director of Nursing/Acting Abuse Coordinator) to (State Agency) documents the following: "This is to report an allegation of abuse of a resident's belongings. A CNA was reportedly wearing (R2)'s wig..."

On 4/7/16 at 1:15 PM, E8 (Assistant Director of Nursing/Acting Abuse Coordinator) stated, "It was brought to my attention that two CNA ' s (Certified Nursing Assistants) were in (R2)'s room, put (R2)'s wig on and was dancing around. This upset (R2).The CNA's were (E4 and E5)..."

On 4/7/16 at 2:20 p.m., E6 (Licensed Practical Nurse) stated that on 12/10/15 (E6) saw a picture of (E4 and E5) wearing wigs on a (Social Media Picture Website). E6 stated, "The picture only lasts a few seconds. I (E6) saw (E4 and E5) with wigs on (E4 and E5)'s heads in a picture. I (E6) tried to take a screen shot of it, but it only lasts a short time and it (the picture) was already gone. I (E6) couldn't tell where they were just that they (E4 and E5) were wearing wigs. The next day, (R2) complained to (E21, former Certified Nursing Assistant). E21 went and got E7 (Licensed Practical Nurse) and (E7) came and told me (E6). It was approximately 8:00 p.m...(E4 and E5, Certified Nursing Assistants) were smiling in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003388	A. BUILDING: _____ B. WING _____	04/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP MANOR	1209 21ST AVENUE ROCK ISLAND, IL 61201

(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	Continued From page 21	S9999		

picture thinking they (E4 and E5) were funny..."

On 4/11/16 at 12:09 PM, E7 (Licensed Practical Nurse) that on 12/11/15 at approximately 7:00 PM, (R2) become upset after a (E21, former Certified Nursing Assistant) attempted to give (R2) a shower. E7 stated, "(R2) was hysterical. (R2) was trying to kick (E21) out of the room. (R2) thought that (E21) was one of the CNA's (Certified Nursing Assistants) that was wearing (R2's) wigs (on 12/10/15). I (E7) talked to (R2) and calmed (R2) down and then (R2) allowed (E21) to care for (R2). I (E7) went and told (E6) what (R2) had told me and (E6) said 'Wow it really happened.' (E6) said to me (E7) that (E6) had seen a picture of (E4 and E5) last night (12/10/15) posted on a (Social Media Picture Website) and (E4 and E5) were wearing wigs... (R2) continued talking about this for a couple weeks. (R2) would become upset about something, but it seemed that the root of the problem always went back to (E4 and E5) wearing (R2)'s wigs. (R2) was extremely upset. (R2) felt degraded and (R2) felt that (E4 and E5) were making fun of and laughing at (R2)."

R2's written interview dated 12/16/15 and signed by (E8) and (E15, Social Service Director) documents the following: "Two girls got real fresh with me the other night. They had my wig in the bathroom and they were posing in the mirror with it on. One was overweight, wearing all black and the other was small. She had black hair and was working the next night. Everything they said was hurtful. I don't think I went to supper. I had ice cream as a snack. The small one was really brazen and paraded around my bed, she grabbed the wig and I asked her to put it on the stand but she went into the bathroom and was posing in the mirror." R2 then denied spilling anything on R2's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003388	A. BUILDING: _____ B. WING _____	04/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP MANOR	1209 21ST AVENUE ROCK ISLAND, IL 61201

(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	Continued From page 22	S9999		

wig and stated, "They were laughing a lot. They were dancing around with my wig on. Making fun of me. Why are you asking me so many questions. You don't care. You don't care! I didn't spill anything on my wig, they were making fun of me!"

On 4/11/16 at 12:05 PM, R2 was lying in R2's bed. R2's hair was extremely thin and disheveled exposing several areas of R2 ' s scalp. R2's wigs were located and neatly kept on a shelf next to R2's bed. R2 stated, " I (R2) do not want to repeat it. I prefer them (E4 and E5) not take care of me ever again. They were very ... (R2 unable to finish statement) when asked about the 12/10/15 incident involving E4 and E5. R2 appeared very withdrawn and avoided eye contact continually staring at the floor. R2 immediately changed the subject of the conversation and stated that R2 was waiting for a meal tray. Upon further discussion and subsequent mention of the 12/10/15 incident, R2 stated, " I (R2) hate this place." When R2 was asked how E4 and E5 (Certified Nursing Assistants) made R2 feel when E4 and E5 were wearing R2's wigs on 12/10/15, R2 again stared at the floor and avoided eye contact, sat in silence for approximately one minute and with a flat affect did not answer the question and stated, "You can go anytime now. "

R2's current care plan has no mention of the above abuse investigation conducted and does not instruct staff to monitor for any adverse behaviors associated with the event.

On 4/11/16 at 9:35 a.m., E24, Care Plan Coordinator, verified that R2's care plan was not updated after the 12/10/15 incident of abuse involving R2, E4 and E5 and stated it should have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003388	A. BUILDING: _____ B. WING _____	04/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP MANOR	1209 21ST AVENUE ROCK ISLAND, IL 61201

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S9999	Continued From page 23 been. R2's Social Service notes dated 11/3/15 - 2/1/16 have no documentation of any follow up to the incident with R2 and E9. On 4/14/16 at 12:30 p.m., E15, Social Service Director, stated, "If any type of abuse was proven, I would do follow up." E15 then stated that R2 had not received any referral or follow up to a psychologist, psychiatrist or counseling. 2. R24's Initial Incident Report dated 1/15/16 documents that an abuse investigation was initiated on 1/15/16 regarding an allegation of an "inappropriate comment" made on 1/13/16 to R24 by E9 (Former Certified Nursing Assistant). E10 ' s (former Certified Nursing Assistant) written statement dated 1/13/16 at 8:30 PM documents the following: "While myself (E10) and (E9) were in (R24) ' s room cleaning (R24) up for bed, (E9) leaned (E9)'s head around to look at (R24) and said, 'Am I (E9) getting you riled up?' After (E9) left the room, (R24) stated (to E10) that (R24) is very uncomfortable with (E9) working with (R24) because of what (E9) says and (E9) touches (R24)." On 4/6/16 at 1:10 p.m., E10 verified the above written statement and stated, "Sometimes when you ' re wiping a male in that area, blood begins to flow and they can't help it (getting an erection). " E10 indicated that R24 began to get an erection when E9 was cleaning R24 ' s peri-anal area. E10 then stated, "After it (incident) occurred, I (E10) called the (E11, Licensed Practical Nurse) into (R24)'s room...When (E11) was in the room on 1/13/16, I told (E11) what I (E10) had witnessed. (E11) asked (R24) how (R24) felt and (R24) said	S9999		

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S9999	Continued From page 24	S9999		

that (R24) didn't want (E9) back in the room at all." E10 then stated that E10 felt E9's comment was indeed, "Abusive in nature because the way (E9) said it and the look on (E9)'s face. It was degrading to (R24)."

E12 ' s (Licensed Practical Nurse) written statement dated 1/15/16 documents the following: "On 1/14/16, (R24) was sitting by the nurse's station and stated that (E9) was inappropriate with (R24) again last night. (E12) asked (R24) what happened and (R24) said (R24) was being cleaned up by (E9, Former Certified Nursing Assistant) and (E10, Former Certified Nursing Assistant) was assisting (E9) and (E10) was standing by (R24) as (R24) was telling (E12) that when (E9) was wiping (R24), (E9) asked (R24) if that felt good or excited (R24) [I (E12) couldn't remember which term] but (R24) stated it made (R24) feel uncomfortable..."

On 4/6/16 at 12:20 PM, E12 verified the above written statement.

On 4/7/16 at 9:52 AM, E12 stated, "There was one other occasion when (R24) mentioned that (E9) had made (R24) feel uncomfortable. It was about a week before (R24) told (E12) about the comment that (E9) made on 1/13/16. (R24) said that (E9) rubbed (R24) ' s back and it made (R24) feel uncomfortable. (E12) asked (R24) why and (R24) said (R24) had (R24)'s shirt off at the time (E9) started rubbing (R24) and (R24) didn't want (E9) back in (R24)'s room...I (E12) can see why people felt uncomfortable. I (E12) even felt uncomfortable with (E9)..."

At this same date and time, E12 stated, "(R24) is pretty easy going. It was out of character for (R24) to complain about someone. E12 then

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S9999	Continued From page 25	S9999		

stated that R24 looked shocked when R24 told E12 about the 1/13/16 incident and, "(R24) was upset. (R24) may have been trying to mask it because (R24) was in the Army and is not an overly emotional person. If it happened to me (E12) or my parents, I (E12) would be really upset. (R24) possibly could be humiliated or embarrassed from a comment like that."

E11's (Licensed Practical Nurse), undated written statement documents the following: "On 1/14/16, (R24) stated that (E9) made an inappropriate comment about getting (R24) riled up while (E9) was cleaning (R24)'s backside. (R24) stated that (R24) was uncomfortable with (E9) giving (R24) cares.

On 4/6/16 at 12:15 p.m., E11 stated that R24 told E11 that R24 was uncomfortable with E9 providing care to R24.

On 4/6/16 at 11:45 a.m., R24 stated that E9 (Former Certified Nursing Assistant) made a remark to R24 on 1/13/16 that, "Made me (R24) very uncomfortable." R24 then stated that E9 would, "Rub (E9) ' s hands on my shoulders and it made me (R24) feel uncomfortable. It takes a lot to make me (R24) feel very uncomfortable. If a man did that to a woman, then he would be in big trouble ... I (R24) did not want (E9) touching me like (E9) was. It was more inappropriate than friendly. I (R24) let it go by for a while, a few weeks, before I (R24) said anything."

On 4/7/16 at 11:45 a.m., R24 stated that when E9 touched and rubbed R24's shoulders, it, "Creeped me (R24) out. I (R24) do not like (E9)." R24 then stated that the comment E9 made to R24 on 1/13/16, "Surprised me (R24). I (R24) was uncomfortable and upset and wanted it

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S9999	Continued From page 26	S9999		

addressed." R24 then stated that R24 prefers to no longer discuss the 1/13/16 incident.

On 4/6/16 at 2:50 PM, E8 (Assistant Director of Nursing/Acting Abuse Coordinator) stated, "(E12) stated that (R24) had expressed feelings that (E9) made comments that made (R24) feel uncomfortable. (E10) was in the room at the time and witnessed the comment...They (the staff) thought it was inappropriate...It's not right..."

On 4/7/16 at 11:04 AM, E8 stated that something was brought to E8's attention approximately a week to a week and a half before the 1/13/16 incident involving R24 and E9 by E12. E8 stated that R24 said R24 was uncomfortable after E9 gave R24 a back rub. E8 then stated, "I think it (E9's comment to R24 on 1/13/16) was inappropriate..."

E9's signed Performance Correction Notice dated 1/20/16 documents the following: "You made an inappropriate comment to a resident while caring for him. The resident was in a compromising position, as you were providing personal care to his private area. You stated to the resident while cleansing him 'does this get you riled up?' This is inappropriate and made the resident feel uncomfortable. While this may not constitute direct abuse, this is considered borderline both physically and verbally. The resident is not confused and is a reliable source. This is a violation of the harassment policy as well. Your employment at (the facility) is terminated."

R24's Social Service notes dated 12/28/15 - 3/24/16 have no documentation of any follow up to the incident with R24 and E9.

On 4/14/16 at 12:30 p.m., E15, Social Service

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S9999	Continued From page 27 Director, stated E15 did not follow up with R24 after the 1/5/16 and 1/13/16 incidents involving R24 and E9 because, "I (E15)didn't see any reason to." E15 then stated that R24 had not received any referral or follow up to a psychologist, psychiatrist or counseling. R24's current care plan has no mention of the abuse investigation conducted on 1/15/16 and does not instruct staff to monitor for any adverse behaviors associated with the event. On 4/7/16 at 1:55 p.m., E24, Care Plan Coordinator, verified that R24's care plan was not revised after the 1/13/16 incident of abuse involving R24 and E9. (B) 300.615e) 300.615f) Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information e) In addition to the screening required by Section 2-201.5(a) of the Act and this Section, a facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons 18 or older seeking admission to the facility, unless a background check was initiated by a hospital pursuant to the Hospital Licensing Act. Background checks shall be based on the resident's name, date of birth, and other identifiers as required by the Department of State Police. (Section 2-201.5(b)	S9999		

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S9999	Continued From page 28	S9999		

of the Act)
f) The facility shall check for the individual's name on the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections sex registrant search page at www.idoc.state.il.us to determine if the individual is listed as a registered sex offender.

This requirement is not met as evidenced by:

Based on interview and record review, the facility failed to complete all required background checks within twenty-four hours of admission and/or sex offender website checks upon admission for two residents (R32 and R33) of 10 reviewed for admission screening on the supplemental sample.

Findings include:

The facility's Admission Criteria policy (Revised October 2012) documents the following: "In accordance with state and federal rules, this facility will conduct a sex offender background check on all residents requesting admission to our facility...In addition, criminal background checks will be conducted on all admissions..."

1. The facility's undated Admission Log documents that R32 was admitted to the facility on 3/16/16.

R32's UCIA (Uniform Conviction Information Act) background check documents the request for R32's background check was not submitted until 3/18/16.

On 4/5/16 at 1:15 p.m., E25, Medical Records, verified that R32's UCIA background request wasn't submitted until 3/18/16 and stated, "It was

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S9999	Continued From page 29 missed." 2. The facility's undated Admission Log documents that R33 was admitted to the facility on 3/7/16. R33's Illinois Sex Offender Registration website check and Illinois Department of Corrections sex registrant search page check documents both of these checks were completed on 12/5/11. On 4/5/16 at 1:15 p.m., E25, Medical Records, stated that R33's Illinois Sex Offender Registration website check and Illinois Department of Corrections sex registrant search page check was not completed at R33's time of admission to the facility, "We checked them back in 2011 when (R33) was admitted to our independent living apartments." (ND)	S9999		