

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 14E579	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/05/2020
NAME OF PROVIDER OF SUPPLIER ROCK RIVER GARDENS		STREET ADDRESS, CITY, STATE, ZIP 3601 SIXTEENTH AVENUE STERLING, IL 61081	
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 0602 Level of harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that a resident was free from misappropriation of funds for 1 of 3 residents (R1) reviewed in the sample of 7. The findings include R1's face sheet shows he was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. His Psychosocial assessment dated [DATE] shows that he is forgetful, has an impaired short term memory. R1's facility assessment dated [DATE] shows that he has an impaired cognitive functioning, disorganized thinking, and difficulty focusing. His current care plan shows that he has had a decline in participating in activities and altered socialization starting 9/1/2018. The same care plan shows that on 1/21/2020 he had a legal guardian appointed (V6). On 8/4/2020 at 8:30 AM, V6 said that she was alerted by the facility during a care plan meeting in 6/2019 that R1 had not been paying for his room and board. V6 said she questioned them why it was not being paid because he received social security funds which are on a direct express debit card and is being kept locked in the desk of V9 (Former Social Services at the facility). She said V9 was supposed to assist R1 with paying his room and board with those funds. She decided to look into what was happening with R1's debit express card but had to obtain guardianship before they would disclose any financial information to her which she did do. Upon obtaining the statement she alerted local law enforcement because there were numerous charges and payments made from his card that she knew he had not made. One being a US cellular phone bill and other various charges to casinos, for gas, and large amounts of money from ATM withdrawals totaling over \$15,000. V6 said when she spoke with R1 he told her he had not made the charges. On 8/5/2020 at 9:36 AM, V6 said that R1 was not allowed to leave the facility unless it was with family or a staff member. She can only recall one time he did leave the building with staff for an activity. She said he does not have his drivers license, does not have a car, he does not have a US cellular provided phone bill, he does not pay utility bills, he cannot even go into a casino if he was allowed to because he doesn't have his drivers license. V6 said ultimately she was able to prove that it was not R1 who used the card and the direct express bank did return the money. On 8/4/2020 at 10:56 AM, V1 (Acting Administrator) said that she received a call from a police officer on 4/27/2020 who was investigating some other incidents involving R9 that occurred at the facility, and was alerted to the fact that R1 had the missing money from his debit card. She said that V9 was terminated from the facility in July of 2019 for inappropriately using other residents trust fund and taking money out for her personal use. She also said that V9 did tell her that she in fact did have R1's debit card locked up in her desk during the time frame indicated that the charges occurred. She said absolutely it is possible that V9 could have taken R1's card and taken money out. V1 said for R1 to have been able to make the charges or take money out, the facility would have needed to transport him. V1 said she is aware there is an ongoing criminal investigation into V9. On 8/4/2020 at 12:11 PM, V2 (Business Office Manager) said that she had heard talk in the facility that V9 had been using R1's debit card for herself and had used the money that was suppose to be paid for R1's room and board. On 8/4/2020 at 8:30 AM, V3 (Social Worker) said that trust fund cards are kept in the business office locked up. She said her understanding is that what happened was someone was using R1's social security debit card. On 8/4/2020 at 12:30 PM, V7 (Social Security Claims Specialist) said that the express cards are just like a debit card from a bank. Someone could easily use another persons card, and if there is evidence that fraud occurred the debit express linked bank could refund the money. On 8/4/2020 at 8:20 AM, V8 (Illinois State Police Medicaid Fraud Control Bureau) said he was assigned the case by the local authorities from Whiteside county. He said that V6 was able to gain access to R1's record and that is how the case came about. She noticed charges in all kinds of places that R1 would not have made, casinos, gaming lounges, buying gas, paying for phone bills and taking out large amounts of money from ATM's. V8 said there is video surveillance of V9 using R1's debit card at Casey's buying gas, and at a ATM taking out \$700. He was also able to get records showing that V9 paid her \$200 US cellular phone bill with R1's debit card. She also used R1's debit card at western union to transfer herself \$771 from his account. V8 said other additional charges that he was able to track between 11/2018 and 7/2019 were for gaming lounges, casinos, restaurants, utility bills, totaling over \$16,000 where V9 used R1's debit card. V8 said he did interview V9 and she told him that she in fact had R1's debit card in her possession for the time frame in question but R1 had told her to make the transactions for cash. However when V8 questioned V9 about paying her cell phone bill and utility bills, and buying gas, and using western union she denied that. V8 said that R1 due to his mental illness was not leaving the facility. He additionally said he has no doubt that V9 made these charges and he has turned over his completed investigation to the attorney general to obtain a federal grand jury indictment for V9. V8 provided this surveyor with R1's bank statements for the time frame indicated which show numerous withdrawals from R1's account to various locations as specified above during the time frame of 11/2018 to 7/2019. V9's employee file shows that she started employment with the facility on 2/26/2018 and was terminated from the facility on 7/19/2019 for failing to follow resident trust procedures. (taking money from resident accounts for her personal gain). The facility's Abuse Prevention Program policy page 59 dated 2/2020 states, This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, and exploitation . The same policy on Page 68 states, misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary, of permanent use of a resident's belongings or money without the resident's consent.</p>		
F 0609 Level of harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>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 the facility failed to report to the state agency an allegation of misappropriation of resident funds for 1 of 3 residents (R1) reviewed for misappropriation in the sample of 7. The findings include: R1's facesheet shows he was admitted to the facility on [DATE] and has [DIAGNOSES REDACTED]. On 8/4/2020 at 10:56 AM, V1 (Acting Administrator) said she was alerted by local law enforcement officer on 4/27/2020 of an allegation that R1's social security debit card had been used by a former employee of the facility. V1 said after she spoke with the officer, then she contacted the facility's regional office for guidance and she thought she did not have to report it to the state agency, Illinois Department of Public Health (IDPH) because the money was replaced. V1 admitted it was not reported to IDPH as of the date of the survey (over 3 months later). V1 showed this surveyor an email exchange between herself and V8 (law enforcement officer) dated 4/27/2020 that shows there was evidence that a previous employee (V9) did have access to R1's debit card. The facility's Abuse Prevention Policy dated 2/2020 page 63 section VII External Reporting of Potential Abuse states, .If the events that cause the reasonable suspicion result in serious bodily injury or suspected criminal sexual abuse, the report shall be made to at least one law enforcement agency of jurisdiction and IDPH immediately after forming the suspicion (but not later than two hours after forming the suspicion), otherwise the report must be made no later than 24 hours after forming the suspicion. A written report shall be sent to the Department of Public Health . Five -day final investigation report. Within five working days after the report of the occurrence a complete written report of the</p>		

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 0609 Level of harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>(continued... from page 1) conclusion of the investigation, including steps the facility has taken in response to the allegation, will be sent to the Department of Public Health.</p> <p>Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that an allegation of misappropriation of resident funds was thoroughly investigated for 1 of 3 residents (R1) reviewed for misappropriation in the sample of 7. The findings include: R1's facesheet shows that he was admitted to the facility on [DATE] and has [DIAGNOSES REDACTED]. On 8/4/2020 at 8:30 AM, V6 (R1's guardian) said she was alerted in the summer of 2019 that something seemed wrong with R1's Social Security Direct Express debit card balance. She looked into and assumed someone had taken money from his account so she contacted local law enforcement. On 8/4/2020 at 10:56 AM, V1 (Acting Administrator) said she was contacted by a police officer on 4/27/2020 for another matter and she discovered then that there was also allegations that there was misappropriation of funds for R1. She said she called and talked to the region office for advice after speaking with the officer. She said an investigation was not done because she had nothing to investigate. She didn't think she had to since the money was replaced and she had very little to investigate. V1 presented to the surveyor some hand written notes that she had scratched down on a sheet of paper but no official investigation was done as of the date of this survey. The facility's Abuse Prevention Program policy dated 2/20 Page 65 Step 5. Investigation Procedures states, Regardless of the specific nature of the allegation (physical, sexual, verbal/exploitation/mental, theft or neglect), the investigation shall consist of: A review of the initial written reports; Completion of a written report on the status of the investigation of the occurrence; an interview with the person(s) reporting the incident; Interviews with any witness to the incident; An interview with the resident; Where appropriate, an interview with the resident's attending physician or psychiatrist; A review of the medical records of any residents involved in the occurrence; If the accused individual is an employee, review the personnel file to check for references, background check, and documentation of orientation and training; An interview with staff members having contact with the residents and the accused individual during the period of the alleged incident; Where appropriate, interviews with the resident's roommate, family members, visitors or others who where in the vicinity of the incident; Interviews with other residents to which the accused has regular contact; Interview other employees to determine if they ever witnessed other incidents of mistreatment involving the accused individual; obtain address, phone number and social security number of the accused individual; An interview with the accused individual or individuals (with a witness present); and a review of all circumstance surrounding the incident.</p>		
F 0610 Level of harm - Minimal harm or potential for actual harm Residents Affected - Few			