

STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
STATEMENT OF VIOLATIONS AND PLAN OF CORRECTION

BURNHAM HEALTHCARE

I.D. Number: 0043398

14500 SOUTH MANISTEE
BURNHAM, IL 60633

Date of Survey: 6/8/2004

Incident Report Investigation of 5/18/04

As a result of a survey conducted by representative(s) of the Department, it has been determined the following violations occurred. Please respond to each violation. The response must include specific actions which have been or will be taken to correct each violation. The date by which each violation will be corrected must also be provided. Forms are to be submitted with the original signature.

IMPORTANT NOTICE: THE STATE AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED UNDER PUBLIC ACT 83-1530. DISCLOSURE OF THIS INFORMATION IS MANDATORY. THE FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

"A" VIOLATION(S):

300.690 a)1)2) The facility shall notify the Department of any incident or accident which has, or is likely to have, a significant effect on the health, safety, or welfare of a resident or residents. Incidents and accidents requiring the services of a physician, hospital, police or fire department, coroner, or other service provider on an emergency basis shall be reported to the Department.

Notification shall be made by a phone call to the Regional Office within 24 hours of each serious incident or accident. If the facility is unable to contact the Regional Office, notification shall be made by a phone call to the Department's toll-free complaint registry number.

A narrative summary of each serious accident or incident occurrence shall be sent to the Department within seven days of the occurrence.

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- 300.1010 h)** **The facility shall notify the resident's physician of any incident, injury, or significant change in a resident's condition that threatens the health, safety, or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury, or change in condition at the time of notification.**
- 300.1220 b)3)** **The DON shall supervise and oversee the nursing services of the facility including:**
- 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 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.**
- 300.3210 o)** **The facility shall also immediately notify the resident's family, guardian, representative, conservator and any private or public agency financially responsible for the resident's care whenever unusual circumstances such as accidents, sudden illness, disease, unexplained absences, extraordinary resident charges, billings, or related administrative matters arise.**
- 300.3240 a)b)c)d)f)** **AN OWNER, LICENSEE, ADMINISTRATOR, EMPLOYEE OR AGENT OF A FACILITY SHALL NOT ABUSE OR NEGLECT A RESIDENT. (Section 2-107 of the Act)**
- A FACILITY EMPLOYEE OR AGENT WHO BECOMES AWARE OF ABUSE OR NEGLECT OF A RESIDENT SHALL IMMEDIATELY REPORT THE MATTER TO THE FACILITY ADMINISTRATOR. (Section 3-160 of the Act)**
- A FACILITY ADMINISTRATOR WHO BECOMES AWARE OF ABUSE OR NEGLECT OF A RESIDENT SHALL IMMEDIATELY REPORT THE MATTER BY TELEPHONE AND IN WRITING TO THE RESIDENT'S REPRESENTATIVE. (Section 3-610 of the Act)**

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**300.690a)1)2) A FACILITY ADMINISTRATOR, EMPLOYEE, OR AGENT WHO BECOMES AWARE 300.1010h) OF ABUSE OR
300.1220b)3) NEGLECT OF A RESIDENT SHALL ALSO REPORT THE MATTER
300.3210o) TO THE DEPARTMENT. (Section 3-610 of the Act)**

**300.3240a)b)c)d)f) RESIDENT AS PERPETRATOR OF ABUSE. WHEN AN INVESTIGATION OF A
(Cont'd) REPORT OF SUSPECTED ABUSE OF A RESIDENT INDICATES, BASED UPON
CREDIBLE EVIDENCE, THAT ANOTHER RESIDENT OF THE LONG-TERM
CARE FACILITY IS THE PERPETRATOR OF THE ABUSE, THAT RESIDENT'S
CONDITION SHALL BE IMMEDIATELY EVALUATED TO DETERMINE THE
MOST SUITABLE THERAPY AND PLACEMENT FOR THE RESIDENT,
CONSIDERING THE SAFETY OF THAT RESIDENT AS WELL AS THE SAFETY
OF OTHER RESIDENTS AND EMPLOYEES OF THE FACILITY. (Section 3-612 of
the Act)**

These REGULATIONS are not met as evidenced by:

Based on resident and staff interviews, review of the residents' clinical record, facility's policies and incident reports, the facility failed to follow its abuse policy in the following areas:

- 1. Failed to investigate an incident involving one resident's (R2) sexually aggressive behavior toward another resident (R3), who is cognitively impaired and has the potential to be abused.**
- 2. Failed to protect R3 from R2 after the incident occurred and failed to send R3 for medical evaluation.**
- 3. Failed to conduct a thorough investigation of the incident when it occurred, and again after a document containing some of the details of the incident were made available to the administrator.**
- 4. Failed to protect other female residents and staff in the facility from R2's continued inappropriate/offensive comments, touching, genital exposures, and sexual coercion by not implementing appropriate monitoring and supervision.**

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 300.3240a)b)c)d)f)
 (Cont'd.)

5. Failed to report the alleged abuse to the appropriate outside agencies and to R3's responsible party.

Findings include:

Review of R3's clinical record found documentation that R3 is 74 year old female with the diagnosis including: "Dementia", "Hypertension" and history of "Cardiovascular Accident". On 05/24/04 and 6/3/04, surveyors observed R3 wandering in the hallways of the Annex area on the first floor of the building. Surveyor tried to engage R3 in conversation, but R3 was observed to be severely cognitively impaired and could not answer any questions.

R2 is a 48 year old resident who was admitted to the facility on 03/11/04 with diagnosis including: "Psychosis with Agitation". R2 also has a history of inappropriate sexual behavior as documented in the nursing and psychosocial service notes. During the investigation, R2 was not observed by surveyor because he no longer resided at the facility.

During an interview on 05/25/04 with R1, R1 expressed concerns about the safety of R3 in the facility. R1 told surveyor, while in his room one day (could not remember the date), he heard a "scuffling" going on behind his roommate's (R2) privacy curtain. R1 reported he went to look behind the curtain. R1 said he observed a confused elderly woman (R3) "naked" and running around the room.

R1 stated he asked R2 why was he treating R3 like that. R1 said he told R2 that R3 was not "right in the head" (confused). But R1 said R3 responded by telling him that R2 kept "coming into his room" and "getting in his bed". R1 said he then reported the incident to a security guard on duty.

After reviewing 6 months of the facility's incident reports on 05/24/04, surveyors found no documentation of the incident. Surveyors expressed concerns to the administrative staff that there were no reports or investigation of R1's allegations. E1 (administrator) stated he had some knowledge about it. E1 then produced a security report which stated:

"Date of Incident: 05/18/04. Type of Incident: Aggressive Behavior. Person/Persons

Involved: R3... Time of Incident: 6 AM. Location: Annex. Summary: Resident (R2) after being told by nursing staff as well as security to stay away from other resident (R3), he (R2) still became sexually aggressive with the resident (R3). Resident (R2) was sent to the hospital because of his action." E3 (ADON) reported that no abuse investigation was done, and she would start one.

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300.690a)1)2) The security guard on duty on 05/18/04 (E7) was interviewed by phone on 06/07/04. E7 told
300.1010h) surveyor that when R1 informed him that his roommate had a woman in the room, E7 went
300.1220b)3) to the room. When E7 entered the room, E7 reported he observed R3 sitting on R2's bed
300.3210o) dressed in a gown, R2 had his pants opened, and was trying to get R2 to touch his private
300.3240a)b)c)d)f) parts. E7 said he took R3 out of R2's room, wrote a report about the incident, and the report
(Cont'd.) went to his supervisor. E7 said he talked about the incident in front of facility nursing staff, but gave no formal report of the incident to them or directly to administrative staff.

Surveyor attempted to reach E7's supervisor but was not successful.

Surveyor also attempted to reach staff working the shift the day that the incident occurred but was not successful. However, surveyors interviewed on 06/03/04 the 7a.m-3p.m nurse (E6) that transferred R2 out to the hospital on 05/18/04.

E6 reported that the only information he received from the 11p.m.-7a.m. shift on 5/18/04 about any problems regarding R2's behavior was from a CNA (Certified Nurse Aide). E6 said the CNA told him in passing that R2 did not sleep during the night. E6 stated he did not become aware that R2 was having a problem until he heard the second floor paging him. When E6 responded to the page, he was informed that R2 was on the second floor showing his genitalia to female residents and staff. E6 said he called R2's doctor and started the process to transfer R2 to the hospital.

Surveyors questioned E6 about the measures/precautions done to monitor R2 while waiting to transfer R2 to the hospital on 5/18/04. E6 stated that R2 was not monitored during this time and could still move freely about the facility. Surveyor asked E6, based on R2's clinical condition at the time of transfer, what type of intervention was

required. E6 said, "One-to-one monitoring." E6 also did not state that R3 was being protected from R2 during this time.

Surveyor asked E6 if R2 ever manifested this behavior before in the facility. E6 reported that he observed R2 being sexually aggressive toward female residents and staff daily, or every other day. Surveyor asked what did he mean by being sexually aggressive. E6 described R2 grabbing female residents and staff by the arm whispering in their ear. E6 said that female residents and staff would respond by telling him to get away from them. E6 also said staff responded to R2's inappropriate behavior by verbally redirecting him. However, E6 stated that the verbal redirection would be effective only for a little while, and R2 would repeat the inappropriate behavior again.

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300.690a)1)2) On 06/03/04, E3 provided surveyors with an investigation of the incident. However, the
300.1010h) investigation was limited in the staff interviewed.

300.1220b)3) It did not include interviews of staff that were required to monitor R2 on the 11p.m.-
300.3210o) 7a.m.
300.3240a)b)c)d)f) shift.
(Cont'd.)

All the witnesses that were interviewed stated R3 was not observed having sexual intercourse with R2, and did not report the sexually inappropriate acts that R1 and E7 alleged that they observed between R2 and R3 the morning of 05/18/04.

During a phone interview on 06/07/04 at 12:20 p.m., E1, E2, and E3 were informed of concerns regarding the facility not following its abuse policy.

E1 stated, "No resident was harmed." Surveyor asked the administrative staff how did they know R3 was not harmed because there was no evidence anyone assessed R3 after the incident or that she had been sent out for an evaluation. E2 said the CNA's dressed R3 everyday and would know if she was not wearing panties. Administrative staff did not provide any evidence of a medical examination being done to support or not support an occurrence of abuse on 5/18/04.

Review of R2's clinical record found documents of frequent incidents of sexual aggressive behavior toward female residents and staff.

Review of R2's Petition For Involuntary/Judicial Admission dated 04/09/04 states:

"Resident (R2) is sexually aggressive toward staff and female peers, going into peers room and making sexual gestures. Review of R2's Transfer Note dated 04/09/04 states: Resident is sexually aggressive toward female staff and peers, getting into peer room and making sexual gestures."

When R2 was readmitted to the facility from the hospital on 05/05/04, the facility's nursing staff continued to document that R2 had sexually inappropriate/aggressive behavior toward female staff and peers.

Review of the Shift Assessment Sheet (04/09/04, 05/07/04, 05/09/04, 05/10/04, 05/11/04, 05/17/04 and 05/18/04) documented that R2 was acting sexually aggressive toward female peer, and staff found it hard to redirect R2's inappropriate sexual behavior. However, further review of the Shift Assessment Sheet revealed documentation of staff trying to use chemical restraints (Ativan) to address R2's inappropriate sexual behavior, with "minimal effect" (05/09/04) effect on R2's behavior, and "calming effect (05/11/04).

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- 300.690a)1)2) Review of R2' s Petition For Involuntary/Judicial Admission on 05/18/04 states: "Resident**
- 300.1010h) (R2) is sexually aggressive toward peers and female staff; grabbing staff in the hallways,**
- 300.1220b)3) and touching female staff inappropriately."**
- 300.3210o)**
- 300.3240a)b)c)d)f) Review of R2's Transfer Note 05/18/04 states: "Resident (R2) is sexually aggressive towards peers and female staff; touching peers and staff inappropriately, making obscene gesture, while exposing his genitalia to female peer."**
- (Cont'd.)**

Review of the psychosocial notes found documentation of R2 exposing his genitalia to staff and making request to have sex, and telling his therapist he knew he was going to return to jail for raping someone.

Review of the facility's policy on abuse states:

Policy:

"...The facility therefore prohibits mistreatment, neglect or abuse of its residents, and has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, neglect or abuse of our residents. This will be done:

...establishing an environment that promotes resident sensitivity, resident security and

prevention of mistreatment.

-identifying occurrences and patterns of potential mistreatment promptly and aggressively, and making the necessary changes to prevent future occurrences; and
-filing accurate and timely investigative reports."

There is evidence to support that the facility did not follow this aspect of their abuse policy. The facility staff were aware of R2's history of being a convicted sexual offender and manifesting repeated inappropriate sexually behaviors toward female residents and staff in the facility, but made no effort to implement effective treatments or monitoring to manage his behaviors. This failure by facility's staff did not ensure that the facility's environment promoted resident sensitivity, resident and staff security, or prevented R2 from possibly mistreating other residents.

Review of the facility's policy contained the following:

"Definition:

Sexual Abuse includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault."

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The facility's staff failed to identify the aspect of R2's behaviors that were potentially abusive as defined in their policy. E7 observed R2 trying to make a confused elderly resident (R3), suffering from dementia, touch his genitalia. E6 described R2 grabbing female residents and staff, and their response was to tell him to get away from me.
Staff

300.3240a)b)c)d)f)

reported and documented several incidents of R2 exposing his genitalia to them and asking

(Cont'd.)

them to engage in sexual activities. There is no evidence that the physician was made aware of R2's continued aggressive behaviors.

Review of the Facility's Abuse Policy revealed the following:

"Resident Assessment: As part of the resident social history assessment, staff will identify residents with increased vulnerability for abuse or who have needs and behaviors that might lead to conflict. Through the care planning process, staff will identify any problems, goals, and approaches, which would reduce the chances of mistreatment for these residents. Staff will continue to monitor goals and approach on a regular basis."

The facility staff failed to follow this aspect of their Abuse Policy by not revising R2's plan of care after gaining knowledge that he had a history of being convicted for a sexual offense and was manifesting repeated inappropriate sexual behaviors. R3 also had behaviors of wandering that put her at risk by being on the same unit with R2. However, staff did not implement effective interventions to monitor/prevent R3 from wandering into areas that were potentially harmful to her. This resulted in R3 being in R2's room, and facility staff being unaware of what occurred.

Review of the facility's Abuse Policy found the requirements for:

"VI. Internal Reporting Requirements and Identification of Allegations:

Employees are required to report any occurrences of potential mistreatment they observe, hear about, or suspect to a supervisor or the administrator.

Supervisors shall immediately inform the administrator or designee of all reports of potential mistreatment. Upon learning of the report, the administrator or designee shall initiate an incident investigation.

.. Internal Investigation of Allegations and Response

1. Appointing an investigator: Once the administrator or designee determines that there is a reasonable cause for possible mistreatment, the administrator or designee will appoint a person to take charge of the investigation. The person in charge of the investigation will obtain a copy of any documentation relative to the incident, and the Resident Protection Investigation Procedures."

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VII. External Reporting of Potential Abuse

The administrator or designee will also inform the resident or resident's representative of

the report of an occurrence of potential mistreatment and that an investigation is being conducted.

3. Informing the Resident's Representative. The administrator or designee will inform the

resident or resident's representative of the conclusions of the investigation.

4. ...Depending on the seriousness of the incident and the presenting evidence, the administrator may also notify the local police."

After interviewing staff and residents and reviewing the facility's incident reports, surveyors could find no evidence that an incident report was completed for the incident occurring on 05/18/04. The facility policy requires that an incident report be completed

for any occurrence involving possible mistreatment of a resident. E7 observed R3 in R2's room being asked to touch R2's private parts, but there is no evidence this was reported to the nurse to complete an incident report. E1 had some knowledge of the incident, but did not follow the facility's abuse policy when he failed to initiate an investigation of the potential mistreatment of R3 on 05/18/04.

The facility's lack of action resulted in the appropriate outside agencies and responsible parties not being informed of this potential mistreatment of R3 as required by the policy. This failure also resulted in the facility not assessing R3 for any indication or evidence that R3 was harmed or not harmed.

Review of the facility's Abuse Policy states the following on:

"V. Protection of Residents

Residents who allegedly mistreated another resident will be removed from contact with that resident during the course of the investigation. The accused resident's condition shall be immediately evaluated to determine the most suitable therapy, care approaches, and placement, considering his or her safety, as well as the safety of other residents and employees of the facility."

Facility's staff failed to ensure that residents were protected by not monitoring R2 closely after the incident occurred involving R3, and while R2 was waiting to be transferred to the hospital on 05/18/04. E6 reported R2 required one-to-one monitoring, but R2 was allowed to move about freely in the facility while awaiting transfer even though R3 was still in the same area. There was a time lapse of 6 hours (6a.m.-12p.m.) before R3 left the facility.

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300.1010h)

300.1220b)3)

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300.3240a)b)c)d)f)

(Cont'd.)

Based on staff and resident interview, record review, review of incident reports, and observations, the facility failed to:

1. Provide supervision and monitoring for two residents (R2, R3). R2 has a history of sexually inappropriate behaviors toward other female residents and staff. R3 has a history of wandering in and out of residents rooms.

2. Notify the physician of escalating sexual behavior in one resident (R2).

3. Protect one resident (R3) from a sexually aggressive resident (R2).
4. Update care plans for two residents (R2 and R3) to indicate new goals and approaches for these continued behaviors.

This failure resulted in R3 being found in R2's room on 5/18/04 at 6a.m. in a sexually abusive situation. The failure of the facility to monitor R2 and to protect R3 placed other female residents at risk for sexual abuse.

Findings include:

R3 is a 78 year old female admitted to the facility 12/21/03 with diagnoses of dementia, hypertension, status post craniotomy, and iron deficiency anemia. R3 is also a wanderer and goes from room to room in the facility.

On 5/24/04 at 9:00a.m. R3 was observed on the Annex where she lived, wandering the hallways. In the afternoons of 5/26/04 and 6/7/04, R3 was observed on the Annex wandering and attempting to open one of the exit doors. Staff did not attempt to redirect R3.

When surveyors attempted to interview R3 on 6/7/04, she was unable to answer any questions. Staff revealed to the surveyors that R3 is a wanderer and goes in and out of other residents rooms, gets into their beds, and sometimes takes other residents' items.

R2 is a 48 year old male admitted to the facility 3/11/04 from another facility with the diagnoses of psychosis and multiple medical problems. R2 is also a known sex offender.

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| 300.690a)1)2) | Interview with R1 on 5/25/04 at 2:30p.m. in the 3rd floor hallway revealed that on 5/18/04 |
| 300.1010h) | around 6:00a.m. he overheard "scuffling" in his room on the other side of the curtain. |
| 300.1220b)3) | R1 informed the surveyor that he saw R3 naked, running around the other side of the curtain |
| 300.3210o) | and R2 was chasing her. R1 stated, "I told R2 that R3 was not together up here |

300.3240a)b)c)d)f)

(pointing to his head), and he should leave her alone. R2 told him that "she keeps getting in my bed."

(Cont'd.)

R1 informed the surveyor that he reported it to security, and they sent him (R2) out that morning to the hospital."

After reviewing 6 months of the facility incident reports on 05/24/04, surveyors found no documentation of the incident. Surveyors expressed concerns to the administrative staff that there were no reports or investigation of R1's allegations. E1 (administrator) stated he had some knowledge about it. E1 then produced a security report which stated:

"Date of Incident: 05/18/04. Type of Incident: Aggressive Behavior. Person/Persons Involved: R3... Time of Incident: 6 a.m. Location: Annex. Summary: Resident (R2) after being told by nursing staff as well as security to stay away from other resident (R3), he (R2) still became sexually aggressive with the resident (R3). Resident (R2) was sent to the hospital because of his action."

E3 (Assistant Director of Nurses) reported that no abuse investigation was done, and she would start one.

Interview with E7 (security) on 6/7/04 at 2:35p.m. per telephone at the facility in regards to the incident revealed, "what happened was R1 came to me and told me that R2 (roommate) had R3 in their room and she should not be there after 11:00p.m. I went there with R1. I saw R2's pants unbuttoned. R3 was in a hospital gown sitting on R2's bed. R2 was asking R3 to touch his private parts, so I proceeded to escort her out of R2's room."

The surveyor asked E7 how he reported an incident? E7 said "I have to write it down for proof. When I write it down I report it. I stack it with the other reports at the security desk. I put it there for E10 (supervisor) to see it. (E7 said he did not remember telling E10 verbally). The surveyor asked E7 if he reported it to the nursing staff. E7 said, "I reported it to the nurse on duty. I think it was a female nurse. I don't remember since its been a while now if I actually told a nurse. Maybe the certified nurses aide. I'm new here and not too familiar with the staff names. I spoke of it at the nursing station where the nurses were sitting. No one was asked to go with me that night to see what was going on."

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300.690a)1)2) The surveyor asked E7 if he had ever been called for R2 before for acting out sexually.
E7
300.1010h) informed the surveyor that "R2 is very rowdy with staff (females), asking for sexual favors,
300.1220b)3) sexual comments and sexual favors. I've heard of R2 before about his sexual aggressive behaviors on occasions, told to me by staff.
300.3210o)
300.3240a)b)c)d)f)
(Cont'd.) E7 further informed the surveyor that, "when I first started here I was told about the no sexual tolerance policy."

Surveyor also attempted to reach staff working the 11p.m.-7a.m. shift the day that the incident of 5/18/04 occurred but was not successful. However, surveyors interviewed on 06/03/04 the 7a.m.-3p.m. nurse (E6) that transferred R2 out to the hospital on 05/18/04.

E6 reported that the only information he received from the 11p.m.-7a.m. shift on 5/18/04 about any problems regarding R2's behavior was from a CNA (Certified Nurse Aide). E6 said the CNA told him in passing that R2 did not sleep during the night. E6 stated he did not become aware that R2 was having a problem until he heard the second floor paging him. When E6 responded to the page, he was informed that R2 was on the second floor showing his genitalia to female residents and staff. E6 said he called R2's doctor and started the process to transfer R2 to the hospital.

Surveyors questioned E6 about the measures/precautions done to monitor R2 while waiting to transfer R2 to the hospital on 5/18/04. E6 stated that R2 was not monitored during this time, and could still move freely about the facility. Surveyor asked E6, based on R2's clinical condition at the time of transfer, what type of intervention was required. E6 said, "One-to-one monitoring." E6 also did not state that R3 was being protected from R2 during this time. R3 was not transferred from the facility until 12p.m.that day (6 hours after the incident occurred).

Surveyor asked E6 if R2 ever manifested this behavior before in the facility. E6 reported that he observed R2 being sexually aggressive toward female residents and staff daily, or every other day. Surveyor asked what did he mean by being sexually aggressive. E6 described R2 grabbing female residents and staff by the arm whispering in their ear. E6 said that female residents and staff would respond by telling him to get away from them. E6 also said staff responded to R2's inappropriate behavior by verbally redirecting him. However, E6 stated that the verbal redirection would be effective only for a little while, and R2 would repeat the inappropriate behavior again.

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- 300.690a)1)2) Review of the 7a.m. to 3p.m. nursing shift assessment sheet dated 4/9/04, written by E6
 300.1010h) (nurse), there is documented evidence of R2 being "sexually inappropriate, making sexual
 300.1220b)3) advances to female staff and peers; needs redirection momentarily and continues
 behavior
~~300.3210a) soon afterwards. Physician notified with new orders " E6 (nurse) petitioned R2 for~~
 300.3240a)b)c)d)f) involuntary admission to the hospital for psychiatric evaluation. On that petition dated
 (Cont'd.) 4/9/04, E6 documented: "Resident is sexually aggressive towards staff and female
 peers, going into peers room and making sexual gestures."

There is no other documented evidence of R2 being in the facility until a readmission nursing note dated 5/5/04 at 2:30p.m., evidencing an admission from a hospital. E6 documented that R2 was "alert and oriented time three, ambulating with steady gait. Anxious and impatient during the admission assessment; both upper extremities observed with tremors."

Review of the nursing shift assessment sheets revealed documented evidence of the following: 5/7/04 the 7a.m. to 3p.m. shift revealed, "disruptive, harassing female peers and staff, had to be redirected several times." 5/9/04 the 7a.m. to 3p.m. shift revealed, "non-compliant, disruptive, grabbing peers and staff several times this shift, redirected frequently. Ativan by mouth given with minimal effect." 5/9/04, 3p.m. to 11p.m. shift revealed "exhibits inappropriate behavior towards co-peers and staff. 5/9/04, 11p.m. to 7a.m. shift revealed "is very inappropriate, sexual statements." 5/10/04, "non-compliant, sexually preoccupied. Grabbing staff and peers indiscriminately. Had to be redirected several times this shift." 5/11/04, 7a.m. to 3p.m.. shift revealed, "disruptive, grabbing female peers and staff. Had to be redirected several times. Ativan by mouth given as necessary with calming effect." 5/17/04, 7a.m. to 3p.m. shift revealed, "non-compliant, intensive, sexually preoccupied."

Review of the skilled nurses notes only show an entry regarding R2's behaviors for 5/18/04 at 9:40a.m. that revealed, "R2 is reported to be exposing his genital area to female peers while grabbing peers inappropriately. Was redirected verbally but, R2 continued to grab female peers and staff inappropriately. Z5 was made aware with new orders. E6 petitioned an involuntary admission for R2's transfer to a hospital for psychiatric evaluation and documented, " R2 is sexually aggressive towards peers and female staff, grabbing staff in the hallways, touching female staff inappropriately."

On 6/3/04 review of the MAR (medication administration record) revealed that R2 only received the Ativan which was for agitation from 5/7/04 through 5/17/04 once daily. There is no documented evidence of Haldol being administered to R2 for his aggressive behavior which was also ordered. Both medications were ordered to be given on a PRN (as needed) basis.

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300.690a)1)2) There are no indications that Z5 was notified of R2's escalating sexual behaviors since his admission of 5/5/04 until he was notified of the incident on 5/18/04.

300.1010h)

300.1220b)3)

300.3210o)

Z5 was interviewed by phone on 6/7/04 at 1:15p.m. Z5 stated that he was familiar with R2's

300.3240a)b)c)d)f)
(Cont'd.)

behaviors and that had he been notified of the escalating behaviors that were not being managed by current medications, he would have sent him out to the hospital for evaluation. Z5 also stated that if R2 is not stabilized on his medications, he becomes sexually preoccupied and psychotic.

There is no documented evidence of R2 being supervised after the incident with R3. Interview with E6 on 6/7/04 at 10:11a.m. revealed that during his 9:00a.m. medication pass on 5/18/04, he was called to the 2nd floor to get R2 because he was exposing his genitals to the female peers and staff on that unit. E6 informed the surveyor that R2 should have been on 1:1 supervision after the occurrence, but had continued access to other residents in the facility since he was not being restricted. Review of the skilled nurses notes dated 5/18/04 revealed that R2 was not transferred from the facility to the hospital until 12:00p.m. that day. There is also no evidence that R3 was protected from R2 for that 6 hours prior to the transfer, nor were other female residents and staff protected during this time.

E4 (PRSC) informed the surveyor on 6/3/04, "that R2 was not on any specific monitoring for his sexually aggressive behaviors. We relied on verbal reports from staff and other residents. E4 said that R2 would come to her and let her know about his behaviors. Staff did not always inform E4 of all behaviors."

Interview with E8 (consultant-social worker) at 5:30p.m. on 6/3/04 revealed to the surveyor that, "R2 disrobed in front of me one time while in the laundry room as she was helping him to get clean clothing. I work on the medicare team for behaviors, medication compliance and ADL's (activities of daily living). He's delusional i.e., "if I'm his sister, sexual things, rape and things." E8 informed the surveyor that she was not aware of R2 being a sex offender. E8 further stated, "have general goals but non-specific to R2."

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- 300.690a)1)2)** E8 also informed the surveyor that she sees R2 three times a week and has not developed
- 300.1010h)** goals or measurable goals "but were in my mind." The goals are made by the PRSC (patient
- 300.1220b)3)** related services coordinator). I look at the care plans. I only document on the sessions.
- 300.3210o)** Later E8 retracted her statement by saying, I didn't mean what I said about "in my mind."
- 300.3240a)b)c)d)f)** E8 was unable to show the surveyor any documented evidence of measurable goals or approaches to address the statements made by R2 on 3/16/04 during a session where she documented: "He (R2) reported that he was going to jail for rape." E8 also informed the surveyor that she was not sure if R2 was delusional when making this statement or not. The current care plan did not show any updated approaches or plans regarding R2's continued inappropriate sexual behaviors.

Review of the care plan dated 2/18/04 with a goal date of 5/18/04 revealed R3 with a problem: Resident displays confusion due to Alzheimers and Dementia. Behaviors: Resident wanders unit. Goal: Resident will wander only in unit through next review. Approach: Direct resident to desired area. Remove resident from area. Supervise resident throughout shift.

The care plan reveals that R3 is monitored by being redirected by staff. Care plan dated 5/13/04, with no goal date, revealed a problem, behavior: Wanders unit at times, becomes confused on where to go or where she is. Goal: Will wander only within specified boundaries through staff intervention ongoing.

Approaches: redirect resident when confused on whereabouts. Remove from area if annoying others and redirect to go to proper designated areas. The care plan does not address R3 going into other residents rooms, getting into their beds and taking items, or the possible potential for abuse by other residents due to these behaviors.

(A)

