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	14G324	A. BUILDING _____ B. WING _____	C 7/13/04

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W9999	FINAL OBSERVATIONS Surveyor: 10078 STATE LICENSURE FINDINGS: 350.750c) The facility shall develop and implement a policy concerning local law enforcement notification, including: 1) Ensuring the safety of residents in situations requiring local law enforcement notification: 4) Seeking advice concerning preservation of a potential crime scene. 350.750d) Facility staff shall be trained in implementing the policy developed pursuant to subsection (c). 350. 3240a) AN OWNER, LICENSEE, ADMINISTRATOR, EMPLOYEE OR AGENT OF A FACILITY SHALL NOT ABUSE OR NEGLECT A RESIDENT. (Section 2-107 of the Act) 350.3240b) 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 3-610 of the Act) 350.3240f) RESIDENT AS PERPETRATOR OF ABUSE. WHEN AN INVESTIGATION OF A	W9999		

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W9999	Continued From page 10 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 interviews, review of client records, and review of hospital reports and incident reports, the facility: 1. Failed to protect R3 after E4 observed evidence that R3 was sexually abused by R1 on 6/29/2004 and failed to ensure that staff protect other clients at the facility from sexual abuse which resulted in R2 being subsequently sexually abused by R1 on 6/29/2004, as witnessed by E4. 2. Failed to ensure that staff notify the administrator or designee immediately of E4's allegation of R1's sexual abuse to R2 and R3. 3. Failed to preserve the sexual abuse evidence by bathing R3 and R2's taking a shower. 4. Failed to ensure that R1 who was the sexual aggressor and R2 and R3 who were sexually abused, were transferred to the hospital immediately for examination. The facility sent R2 and R3 on the bus to the day-training/workshop	W9999		

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W9999	Continued From page 11 prior to going to the hospital. 5. Failed to ensure that R4 thru R15 received a medical examination to ensure that R1 had not sexually abused any other individuals who live at the facility. Findings include: Review of R1's Individual Service Plan on 7/6/2004, dated 3/17/2004, states R1 is a 39 year old male with a diagnosis of Moderate Mental Retardation, Controlled Seizure Disorder, and Ataxic Gait. Review of Pre-Admission Assessment dated January 17, 1995 and Social Service Assessment dated January 10, 2004 states "has history of engaging in sex with other developmentally disabled males". Review of R1's Sexual Assessment dated 1/28/2004 states R1 "has a history of engaging in sex with other developmentally disabled males". Review of incident reports at the day-training site on 7/7/2004 noted an incident on 3/29/2004 which stated R1 was found in the bathroom stall with another individual (no sexual activity was involved). Review of incident reports at the facility on 6/30/2004, it was noted that R1 had unsolicited Sexual Contact with 2 individuals (R2 and R3). Review of R2's Individual Service Plan dated 3/11/2004 states that R2 is a 39 year old male with a diagnosis of Profound Mental Retardation and Impulse Control Disorder. R2 is non-verbal but communicates basic acceptance/refusal via a limited gestural system.	W9999		

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W9999	Continued From page 12 Review of R3's Individual Service Plan dated 3/24/2004 states he is a 52 year old male with a diagnosis of Profound Mental Retardation, Seizure Disorder, Cranio-Facial Anomaly, and Visually Impaired. R3 is non-verbal but vocal and ambulates with staff assistance with the use of a gait belt. On 6/29/2004, the Illinois Department of Public Health was notified of the following: ..."this morning at approximately 6:20 a.m. (R1) had unsolicited sexual contacted with two other individual in the facility." Review of facility's Attendance Enterprise Attendance Sheet of employees who worked the morning of 6/29/2004 from 12:01 a.m. to 6:30 a.m., shows E4, direct care staff, clocking in at 11:26 p.m. on 6/28/2004 and clocked out at 6:56 p.m. on 6/29/2004. E4 was interviewed on 7/6/2004 at approximately 3:10 p.m. via telephone and states she worked alone from 6/28/2004 at 11:30 p.m. to 6/29/2004 at 6:00 a.m. E4 states she arrived at work at approximately 11:30 p.m. and "the incident" (R1's sexual abuse against R2 and R3) happened around 4:30 a.m.. E4 states she was walking into the women's side of the home and heard a very loud scream. E4 knew the scream sounded like R3. E4 stated she ran to R3's room, and observed R1 coming out of R3's room. E4 states she went into R3's room and saw what appeared to be semen running out of R1's mouth and feces smeared on his face. E4 then pulled back the bed covers and observed feces smeared on his butt and small amount of blood spots on the bed.	W9999		

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W9999	Continued From page 13	W9999		

E4 stated, at that moment, she heard the doorbell ring. E4 answered the door. It was 2 ladies (Z2 and Z3) from the laboratory who were there to draw the client's bloodwork. E4 stated "they asked for R3; but I (E4) told them he was a mess, and I had to clean him. So I proceeded to go get the clients who needed to have their blood drawn. They did the women first. Then the men, and the last 2 clients that needed to have their blood drawn were R1 and R3."

E4 stated the laboratory lady asked for R1, and she went to the men's side and observed R2's door closed. When E4 opened the door, she saw R2 was naked from the waist down, facing the dresser with his legs spread apart, and R1 sitting on the floor between R2's legs masturbating with one hand and had his finger or an object in R2's rectum. R2 ran to his bed when he saw E4. E4 assisted R1 up off the floor. E4 took R1 to have his blood drawn, and then cleaned R3's face so he could have his blood drawn. E4 stated that R3 was the last person to have his blood drawn. The lab work was drawn in his room while he was in bed. Then the laboratory ladies (Z2 and Z3) left. E4 states she is unable to remember what time Z2 and Z3 left the home.

Interview with Z2 and Z3 on 7/7/2004 stated they arrived at the facility between 4:30 a.m. and 4:45 a.m. and left the facility between 5:00 a.m. and 5:15 a.m. Z2 and Z3 stated upon their arrival, there was one staff in the home, E4 (direct care staff). Z3 stated she asked for R3 first, but E4 states "he is full of B.M. and she had not cleaned him up yet." Z2 and Z3 stated E4 seemed nervous, but E4 stated this was the first time with the lab. Z2 and Z3 stated E4 got each client who was needed for

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W9999	Continued From page 14	W9999		

blood work, except R3, who was drawn last and drawn in his bedroom. Z3 stated she did not observe anything unusual about R3. He was laying quietly in his bed, his face was clean, and no feces was observed

E4 stated she proceeded to get some of the clients up out of bed and gave R3 a shower. E4 stated the cook called off, and she then proceeded to make breakfast which consisted of milk, juice, toast, and cereal and offered seconds to client who wanted them while E5 assisted the clients who were not up yet . E4 states she does not recall the exact time the clients ate their breakfast, but it was before 7:15 a.m. E4 stated she assisted the clients who attended Workshop A onto the bus between 7:15 a.m. and 7:30 a.m. E4 states that she did not notify anyone of the sexual abuse until after E5, direct care/housekeeper, came in at 6:00 a.m. After E4 told E5 about the sexual abuse, E5 told her she "needed to call someone". Review of E5's Attendance Enterprise Attendance Sheet shows that E5 clocked in, on 6/29/2004, at 6:30 a.m. and clocked out at 6:57 p.m. E4 failed to protect the other clients at the facility from R1 from further abuse by E4's continuing with her normal morning routine of bathing and preparing the morning meal prior to notifying the administrator/designee of 2 sexual abuse incidents. The first sexual abuse occurred at approximately 4:30 a.m. to 4:45 a.m. The Administrator was not notified until approximately 6:45 a.m. on 6/29/2004.

Interview with E5 on 7/6/2004 stated she arrived at work at 5:58 a.m. and was not able to clock in until 6:00 a.m. on 6/29/2004 (Surveyor's review of Attendance Enterprise Attendance Sheet states

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W9999	Continued From page 15 E5 clocked in at 6:30 a.m.). E5 states E4 told her about the sexual abuse to R2 and R3 by R1. E5 stated she told E4 she needed to call someone about the incident. E5 stated E4 called E2 (RSD), and E2 arrived between 6:30 a.m. and 6:40 a.m. When E2 came in the home, "she went to R1's room to talked with R1 and this is when R1 attacked her; then he hit me (E5) in the chest. All the clients who go to workshop A were sent to the bus by E4 while E2 was talking on the phone with E1. This included R2 and R3. When E2 got off the phone and realized R2 and R3 were gone to the day training, I (E5) was told to go get R2 and R3 at the workshop. E5 stated she got to the workshop before the bus. When the bus arrived, she returned R2 and R3 to the home. E5 stated she and E4 took R2 and R3 to the hospital and arrived at the hospital at approximately 9:00 a.m." On 7/6/2004, R2 and R3 Emergency Room Treatment Records dated 6/29/2004 were reviewed and showed "Diagnosis Sexual Assault". R2 and R3 had samples of secretion from mouth and rectum taken; scrapes under fingernails to collect hair and skin samples; and photos taken.... R3 was prescribed Metronidazole 500 mg. and Zithromax 250 mg and given Ceftriaxone Injection at the emergency room. Z1, Detective, was interviewed on 6/30/2004 and stated the police department received a call from the facility at approximately 8:10 a.m. to come to the facility. Interview with E2, on 7/8/2004, revealed that R1 was taken to Hospital A by the police and subsequently transferred to Hospital B. R2 and R3 were examined and released from Hospital A.	W9999		

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W9999	Continued From page 16 The facility staff failed to preserve the evidence of the sexual abuse between R1, R2, and R3. R2 and R3 were sent to day-training rather than being transported immediately to the hospital for a medical examination. Interview with E2, RSD, on 7/7/2004, revealed that E2 was en route to the facility at approximately 6:25 a.m. when E4 called her hysterical stating "no cook came". E2 stated she arrived at the facility at approximately 6:30 a.m. and E4 was in the kitchen hysterical and it took about 15 minutes to calm her down. E4 stated to E2 that R1 had molested 2 clients and told me what had happened. E4 stated to E2 that after the lab left, she bathed R3. E5 told her (E4) to call her (E2) about the incident. E2 stated she immediately ran to the back and saw R2 and R3 were dressed, and she asked E4 if she had bathed them and E4 stated "yes". E2 stated she told E4 the client should not have been bathed. E2 stated this conversation occurred after 7:00 a.m. . Interview with E3, nurse, on 7/6/2004 revealed that E3 was called at home by E1 (don't remember the time) and arrived at the facility at approximately 9:00 a.m. E3 states R1, R2, and R3 were not at the facility, but at the hospital. On 7/8/2004, E3 was asked if any of the other clients who live at the facility were examined to ensure that R1 had not been sexually abusive towards them. E3 stated only R1, R2, and R3 were examined at the hospital. The facility failed to ensure that R4 thru R15 have a medical examination to ensure that R1 had not sexually abused any other individual at the facility on 6/29/2004 Review of Facility Policy NO: 5.52 revised 05/03;	W9999		

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W9999	Continued From page 17 Subject: Individual Rape or Sexual Assault was reviewed on 7/7/2004 and states the following: A. Any employee of the agency who receives a report, or who suspects, that rape or sexual assault has occurred shall immediately notify the designated management staff and supply all relevant information. B. In cases where rape is suspected or discovered, the Administrator shall 1. Immediately have the individual transported to the emergency room for examination and securing of evidence..... D. The chain of evidence must be secured and maintained. 1. Do not bathe the individual or allow her/him to bathe before medical examination. 2 If the individual has changed clothes, put the clothing worn at the time of the alleged rape or sexual assault in a paper bag. 3. Staff member on duty shall handle this evidence and place it in a locked, secure location. Only one person shall handle this evidence until the medical examination has been completed.	W9999		