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

PINE LAWN MANOR **0045708**

Facility Name **I.D. Number**

200 POPLAR DRIVE, SUMNER, ILLINOIS 62466
Address

Date of Survey: 12/23/2003

Incident Report Investigation of December 8, 2003

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.

"REPEAT A" VIOLATION(S):

Facility failed to follow the IPOC for the survey of July 30, 2003, by failing to ensure that ". . . Review of existing policicies and procedures regarding sexually aggressive residents to identify:

. . . Staff are informed of the level of supervision required for each resident.

. . . All allegations of sexual assault will be thoroughly investigated.

. . . Protection of other residents from a sexually aggressive resident.

. . . Polices and procedures are followed.

350.620a) **The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually.**

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)**

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"REPEAT A" VIOLATION(S):

350.3240f) **RESIDENT AS PERPETRATOR OF ABUSE. WHEN AN INVESTIGATION OF A 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)**

Based on interview and file review, the facility has neglected to implement their own policies and procedures that prohibit mistreatment, neglect or abuse of the client as evidenced by:

1) The facility failed to provide necessary monitoring and supervision to R3 who has history of inappropriate sexual interactions with others. On 12/02/03, R3 was found engaged in a non-consensual sexual act with R5 (his room mate). R3 was placed on 15-minute monitoring on 12/02/03. Six days after the incident of 12/02/03, R3 was found on 12/08/03 engaged in non consensual sexual act with his other roommate (R4). The facility failed to thoroughly investigate the incidents that occurred on 12/02/03 and 12/08/03 and failed to immediately remove R3 from the bed room that he shared with R4 and R5 whereby ensuring that R4 and R5 were free from client to client sexual abuse. After the 12/08/03 incident, R3 remained in the same bedroom with R4 and R5 until after the surveyor entered the facility on 12/17/03.

Per review of the facility's policy and procedures the facility is to perform an investigation if "A resident is allegedly sexually abused by a staff member, visitor or another resident (sexual abuse allegations include any allegations of sexual penetration, potential sexual touching or using one person for another's sexual gratification, arousal, advantage or profit)...".

Per review of the incidents that occurred on 12/02/03 involving R3 and R5 and the incident that occurred on 12/08/03 involving R3 and R4, the facility failed to thoroughly investigate the incidents of client to client non consensual sexual interactions. In addition, the facility failed to provide R3 (who has history of inappropriate sexual interactions with others) with necessary monitoring and supervision to ensure that his room mates (R4 and R5) were free from further client to client sexual abuse.

Per review of the Admission Information Sheet and the facility's roster, R3 is a 57-year-old male that functions at a severe level of mental retardation and has additional diagnosis of Seizure Disorder, Schizophrenia, and Blindness.

Review of R3's Individual Program Plan dated 09/10/03, identified R3 "had a service objective for inappropriate sexual behavior last year. This has not been displayed lately, but the service objective will be continued..."

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350.3240 a)
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Review of R3's Human Awareness Assessment dated 09/10/03 identified that R3 did not respond to nineteen of the twenty six of the questions regarding sexuality. The assessment identified that R3 "undresses only in private places", "knows what sex he is" and "masturbates or touches his genitals only in private." No recommendations were noted on the assessment. Interview with E4 (Qualified Mental Retardation Professional/QMRP) on 12/18/03 at 11:25 A.M., E4 stated "No" when asked by the surveyor if R3 was receiving sex education training.

2) Incident of 12/02/03 involving R3 and R5

Per review of the Admission Information Sheet, R5 is a 30-year-old male who functions at a profound level of mental retardation and has diagnosis of Psychomotor Developmental Delay with Hydrocephaly. Further documentation identified that R5 requires a guardian.

Review of R5's file on 12/17/03 did not identify that R5 had any significant incidents within the past month to warrant notification of guardian. However, during the investigation on the incident of 12/08/03, the surveyor noted that R3's fifteen minute checks were started on 12/02/03.

On 12/18/03 the surveyor was provided with Nurse's Notes, Nursing Assessment and a QMRP (Qualified Mental Retardation Professional) Note for R5.

Review of R5's Nursing Assessment identified that on 12/02/03 (evening shift) "R5 and another male res. (resident) were found in a non-consensual way by a DT (Developmental Trainer). R5 was in bed and the other male res. had his penis out and had put it in R5's hand. R5 was very upset. Res, were separated. R5's hands were washed and they were put on a 15 min. (minute) checks."

Review of R5's QMRP Note identified that R3 was the client that had been found standing by R5's bed on 12/02/03 and that R3 had been placed on 15 minute checks. Additional documentation was noted to identify that an "incident accident report needed to be filled out." No incident and or accident report was provided to the surveyor regarding the incident of 12/02/03.

Review of the Nurse's Notes for R5 identified that a late entry was made on 12/17/03 for the incident that occurred on 12/02/03. Documentation identified that R3 had put his penis in R5's hands and that the incident had been interrupted by staff. Additional documentation was noted that a complete assessment was done on both clients "...without signs and/or symptoms of injury of sexual penetration were noted."

No documentation was noted within R5's record to identify that R5's guardian had been contacted regarding the incident that occurred on 12/02/03.

Review of the documentation sheets for R3 identified that 15 minute checks were started on 12/02/03. No 15-minute documentation sheets were located for 12/09, 12/10 and of 12/11/03 to identify that the facility had provided R3 with needed monitoring and supervision to protect his room mates from his sexual advances.

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Interview with E1 (Assistant Administrator) on 12/18/03 at 10:45 A.M., E1 confirmed that no incident report or an investigation had been completed by the facility regarding the incident of non consensual sexual interaction that occurred on 12/02/03 involving R3 and R5.

3) Incident of 12/08/03 involving R3 and R4

Per review of the Admission Information Sheet, R4 is a 74-year-old male who functions at a severe level of mental retardation and has diagnosis of Obsessive Compulsive Disorder, Cataracts and a history of Convulsive Disorder and marked Weight Loss. Documentation also identified that R4 requires a guardian.

Review of the facility's investigation and the facsimile document that was submitted to the Illinois Department of Public Health on 12/09/03 identified that, "R3 was noted at R4's bed side with his penis in R4's mouth. Both residents were actively participating. Upon exam, no noted secretions or redness. Neither resident was upset. Staff intervened. No further activity noted. Dr. (doctor), family, and guardian notified." Additional documentation was noted that identified that "staff monitoring R3's whereabouts every 10 - 15 min. (minutes)." Further review of the facility's investigation did not identify the staff who had found R3 and R4 on 12/08/03 and or that the facility had secured statements for the investigation.

Per interview with E2 (Administrator) on 12/18/03 at 12:45 P.M., E2 stated that the facility had investigated the incident of 12/08/03. E2 stated that staff had contacted her the day of the incident and that she had told them to get statements. During this interview, E2 stated that the facility could not find these statements which were completed on 12/08/03. E2 stated that she had contacted E3 (staff member who discovered R3 and R4 on 12/08/03) and that E3 would be at the facility around noon (12/18/03).

Per interview with E3 (Developmental Trainer/DT) on 12/18/03 at 11:55 A.M., E3 confirmed that she had worked on 12/08/03 and observed R3 and R4 in their bedroom that night. E3 stated, "I was walking by the door and I saw R3 by R4's bed. R3 put his penis in R4's mouth. R4 was turning his head, going backwards to keep him (R3) from putting his penis in his mouth. R3 kept on and R4 pushed him away." After reviewing the facility's investigation with E3, E3 stated "No" when asked by the surveyor if the incident was consensual. E3 stated, "When R3 was trying to put his penis in R4's mouth, R4 was trying to pull his head back and R3 kept going forward pushing it in." E3 stated that the nurse (E5) had her sign a statement about the incident on 12/08/03. E3 also stated that she was not interviewed about the incident that occurred on 12/08/03 until she arrived to work on 12/17/03.

Per interview with E5 (licensed Practical Nurse/LPN) on 12/18/03 at 1:25 P.M., E5 confirmed that she had worked on the night of 12/08/03. E5 stated that she had talked with E3 (DT) on 12/08/03 and had her write up a statement. E5 stated that she was told that they (the facility) could not find E3's statement. E5 stated, "When E3 first told me, she didn't tell me all of it." E5 stated that when she read E3's written statement about "R4 was not willing", she (E5) had already written up her initial report. E5 stated, "I wanted to ask E3 again about her statement (about R4 not being willing), but I did not get to talk with her again." E5 stated that she had talked with R4 (on 12/08/03) but he did not answer. E5 stated, "R4 doesn't talk much."

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Per review of the facility's investigation that was completed by E5 (LPN), E5 documented "This resident (R3) has a long history of sexual advances towards others. Is on a 15 min. (minute) check to rule out this behavior, however, his movements are often too quick. A tighter watch program may be necessary to successfully curtail his movements. During the interview with E5 on 12/18/03, E5 confirmed that 15-minute checks were not enough. E5 stated that when staff come in to change R5 during the nights, this wakes up R3. R3 will then wait and then start wandering after staff leave the room.

During the survey, no further documentation was provided to the surveyor that would identify that the facility had taken additional actions after E5 identified within her investigation that a "tighter watch program may be necessary to successfully curtail his (R3's) movements".

Additionally per file review on 12/17/03, no documentation was located in R4's record to identify that any type of incident occurred on 12/08/03, or that R4's guardian was contacted regarding the incident of client to client sexual interactions.

Per telephone interview with Z1 (Guardian of R4) on 12/18/03 at 1:50 P.M., Z1 stated that she was not aware of the non-consensual sexual incident involving R4 and another client of the facility, nor R5. Z1 stated that she was very concerned and would have expected the facility to notify her. Z1 also stated that she had been at the facility on 12/11 and 12/17/03 and no one had even mentioned either of the incidents to her.

Per interview with E4 (Qualified Mental Retardation Professional/QMRP) on 12/18/03 at 11:25 A.M., E4 stated that she found out about the incidents of 12/02 and 12/08/03 on 12/16/03. E4 stated that she had developed and implemented a behavior program to address R3's inappropriate sexual behaviors as of 12/17/03. E4 stated that she was not aware of any other additional safeguards being implemented after the incident of 12/08/03 until R3 was moved from the bedroom that he shared with R4 and R5 to a private room on 12/17/03.

Further review of the facility's policy and procedures on Abuse Investigations identified that the facility failed to implement their policy which identified that "All reports of resident abuse, neglect and injuries of unknown source shall be promptly and thoroughly investigated by facility management." Additionally, under the section marked Policy Interpretation and Implementation, step #8 identified "While the investigation is being conducted, accused individuals not employed by the facility will be denied unsupervised access to residents...".