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

LINCOLN SQUARE
Facility Name

0037044
I.D. Number

202 SOUTH MAIN STREET, JONESBORO, ILLINOIS 62952
Address

10/15/2004
Date of Survey

ANNUAL
Type of Survey

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):

350.620a)
350.700a)
350.1230c)d)2)
350.3240a)d)f)

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.

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.

A registered nurse shall participate, as appropriate, in planning and implementing the training of facility personnel.

Direct care personnel shall be trained in, but are not limited to, the following:

Basic skills required to meet the health needs and problems of the residents.

AN OWNER, LICENSEE, ADMINISTRATOR, EMPLOYEE OR AGENT OF A FACILITY SHALL NOT ABUSE OR NEGLECT A RESIDENT. (Sections 2-107 of the Act)

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)

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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)

These regulations were not met as evidenced by the following:

I) Per review of the facility's policy and procedure on Rape or Sexual Abuse, the policy identified, "It is the policy of this facility to provide a safe environment for the individual receiving services which safeguards against rape or sexual assault." Under the procedure section, the policy identifies that, "sexual abuse includes but is not limited to any sexual penetration or sexual conduct between an individual and another person if the individual has been adjudicated legally disabled, or has a guardian, or is unable to understand the nature of the act or is unable to give knowing consent, or is injured or alleges that there is, or there is evidence of use of force, coercion, or the exchange of money or anything of value.

Additionally, the procedures identified:

"Any employee, upon becoming aware of any occurrence or allegation of occurrence of sexual penetration or sexual conduct among individuals will report the incident immediately to the Resident Service Director.

During initial investigation, the personnel on duty will interview the individual to determine if consent was given by the individual. If the individual is in the mild to moderate range of mental retardation and consent was given and no injuries sustained, staff will document findings and notify the Resident Service Director.

If the individual is in the severe to profound range of mental retardation, they are unable to understand the nature of the act and are unable to give knowing consent.

If the individual reports that they have been raped, the staff assumes consent was not given, or the individual is in the severe to profound range of mental retardation, the individual will be transported to the emergency room immediately for a physical examination. The staff will assure that the individual goes to the emergency room exactly as they are, i.e., without bathing, combing hair, washing hands, or changing clothes. The victim should be encouraged to refrain from urination and/or defecation if possible.

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The Resident Service Director or his/her designee is responsible for notifying the Department of Public Health within 4 hours of the alleged rape or sexual assault. The Resident Service Director or his/her designee is also responsible for notifying local police department, and the individual's family and or guardian of suspected sexual abuse.

All victims should be assessed for sexually transmitted diseases, as ordered by physician..."

During Task II of the survey, the surveyor noted three Incident/Accident Reports that identified that client to client sexual activity had occurred. Further review of these reports identified that on 01/14/04, R15 had been found with blood coming from his rectum and that R15 had been sexually active with R14. The Incident/Accident Report dated 03/08/04 identified that R14 was found in the bathroom with R15 engaged in anal intercourse, and an Incident/Accident Report dated 07/09/04 which identified that R10 had been found with R14 engaged in anal intercourse.

1) Per review of the Incident/Accident Report dated 01/14/04, R15 was found with blood coming from his rectum. Further documentation on the Incident Accident Report identified that R15 had been sexually active with R14 and that more information was located in R15's chart.

Review of the documentation contained in R15's Universal Progress Notes for 01/14/04 identified that staff had noticed "....2 half sized dollar amounts of blood in R15's underwear" when R15 was in the shower. The facility notified the physician, however R15 was not seen by the physician. Documentation identified that, "...that Z4 (physician) stated that if we believed it to be from a hard stool, to monitor thru the night and evaluate in the morning if he needed to be seen... (Name of facility stated.) ruled out any opportunities for sexual assault or penetration..."

No documentation was provided to the surveyors during the survey that would identify that the facility had thoroughly investigated this incident, inclusive of interviews from staff and or any clients that may have been involved, or that this information was sent to the Illinois Department of Public Health.

Review of R15's file identified that R15 is a 39-year-old male who functions at a profound level of mental retardation. Attempts were made during the survey to interview R15. R15 did not respond to any questions or statements made by the surveyor. Confirmed per interview with direct care staff E3 on 10/12/04 at 4:00 p.m. that R15 is nonverbal and would not be able to give verbal consent for sex.

Review of R15's Universal Progress Notes identified that R15 had been found with R14 on 01/01/04, on 01/06/04, and on 02/21/04. Documentation identified:

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01/01/04 (no time specified) "When this writer went upstairs to call guys down for commissary, R15 was found standing facing toilet with pants down. R14 was standing behind him with his private in his hand. No actual contact was observed. This writer asked R14 out of the bathroom and he complied. Will continue to closely monitor situation." No documentation was identified that would indicate that R15 was physically examined by staff or nursing for signs of penetration, or that the R14 was sent to the Emergency Room, or that the Illinois Department of Public Health was notified.

01/06/04 6:10 p.m. "This staff went upstairs and found R15 in another peer's room (R14). He was standing in front of this peer with his shirt held up and his pants unzipped, The other peer was holding R15's penis in his hands stroking it. The door was wide open and hall light and bedroom light out. When this staff turned the hall light on, this is what was going on. This staff redirected both clients..."
6:30 p.m. "After prior incident staff assisted immediately R15's shower. He had pants unzipped et (and) opened had shirt held above waist. This staff observed BM (bowel movement) all over R15's buttocks. Staff will continue to monitor." No documentation was identified that would indicate that R15 was physically examined by staff or nursing for signs of penetration, or that the R15 was sent to the Emergency Room, or that the Illinois Department of Public Health was notified.

Further documentation identified that on 01/07/04, the facility identified that the actions were consensual, however, R15 is to be discouraged from being in R14's room.

Further review of R15's Universal Progress Notes identified that an entry was made on 02/21/04 that identified that R14 was observed by staff playing with R15's penis. No time was specified for the incident.

Review of R15's Individualized Habilitation Plan dated 11/19/03, identified that R15 functions at a profound level of mental retardation and has a legal guardian. Documentation within the Habilitation Plan also identified that R15 requires staff assistance for all self care tasks, that R15 is nonverbal, R15 is independently ambulatory, and that R15 cannot defend his own rights or make medical decisions on his own.

Per interview with E1 (Resident Service Director) on 10/12/04 at 2:40 p.m., E1 stated that he was not sure as to why the facility would have sent R15 to the Emergency Room after the incidents. When the surveyor reviewed the facility's policy and procedure with E1 that identified that all severe to profound clients would be sent to the Emergency Room, E1 stated that he would have to discus this with E2 (Nurse Consultant).

Per telephone interview with Z1 (Guardian) on 10/12/04 at 1:32 p.m., Z1 stated that she was aware of the sexual incidents between R15 and R14. Z1 stated that she did not think that R15 understands the sexual acts, however Office of State Guardian/OSG can not give consent for sex. Z1 further stated that she is guardian for R14 as well. Z1 stated that she had been to

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meetings at the facility where they have discussed R14's sexual behaviors and the consequences of his behaviors that may jeopardize his placement. Z1 stated that she felt R14 understands what he does and has voiced his understanding during their discussions. Z1 stated that she had some concerns with R4 remaining as R14's roommate after R4 was found with rectal bleeding in December of 2003. Z1 stated that R4 had received prompt medical attention, however she still questioned if R4 had been subject to some form of sexual contact from R14. Z1 stated that the facility had switched bedrooms as a precautionary measure.

Subsequent interview with Z1 on 10/14/04 at 4:00 p.m., Z1 stated that she was not aware of the facility's policy and procedure that identified that clients that are functioning at a severe profound level are to be taken to the emergency room for examination upon any occurrence of sexual penetration and or sexual conduct.

E3 (Direct Support Person) was interviewed on 10/13/04 at 4:20 p.m. and stated that she had never seen R15 nor R10 seek out or encourage R14. When E3 was asked by the surveyor if she thought R15 or R10 understood the sexual acts, E3 stated, "No, Sure don't." During this interview, E3 stated that she thought R14 understood what he does regarding his sexual behavior.

2) Review of the Incident/Accident Report dated 03/08/04 identified that R10 was found in the bathroom with R14 engaged in anal intercourse, and an Incident/Accident Report dated 07/09/04 which identified that R10 had been again found with R14 engaged in anal intercourse.

3) Per review of the facility's admission sheet, R10 is a 45 year old male who functions at a profound level of mental retardation. Attempts were made by the surveyor to interview R10 with E3 present on 10/12/04 at 4:00 p.m.. R10 could not respond to any of the surveyor's questions with an intelligible answer. R10 ended the interview by getting up out of the chair and returning into the facility. During this interview, E3 confirmed that R10 would not be able to give consent for sex.

Per review of R10's Individualized Habilitation Plan dated 04/21/04, identified that R10 does not ask for most needs or ask questions, has poor social skills, cannot defend his personal or civil rights and has a guardian, and cannot provide for his domestic needs, manage his physical needs of self preserve in the community.

Review of R10's Universal Notes identified that R10 had five documented incidents of being found engaged in a sexual act with R14. Documentation identified:

12/21/03, R14 found in R10's bed. R10 was lying in bed with his pants and underwear down to his knees with R14 laying next to him. Staff did not observe physical contact but documented that R14 was masturbating. Bed checks were to be done every 15 minutes. No documentation was identified that would indicate that R10 was physically examined by staff or nursing for signs of penetration.

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12/22/03 6:30 a.m. R14 observed by staff coming out of R10's bedroom. R14 was seen putting his private in his pants. No documentation was identified that would indicate that R10 was physically examined by staff or nursing for signs of penetration.

On 12/28/03, documentation was noted that identified that staff found blood on R10's sheet while changing his bed. No documentation was identified that would indicate that R10 was physically examined by staff or nursing for signs of penetration or for any other physical problems that would have resulted in the blood on the sheets.

No further documentation was noted in R10's Universal Progress Notes regarding any further sexual activity between R10 and R14 until 03/08/04 ,even though documentation in R14's file identified that R10 had been found with R14 engaged in sexual activity on 01/04/04, 01/06/04, 01/10/04, 01/13/04 and 01/19/04.

03/08/04 6:20 a.m. Staff observed R10 bent over and that R14 had his penis in his (R10's) rectum. Staff documented that they did not observe R10 to have any blood on him or any tears. Further documentation identified that the facility contacted R10's guardian and R10's physician. Documentation was noted that the facility questioned if R10's guardian fully understood the nature of the incident.
Further documentation identified that a letter was to be sent to the Court of Adjudication to challenge the appropriateness of R10's father maintaining guardianship. No documentation was noted to identify that R10 was seen by his physician after the incident of 03/08/04, or that R10 was taken to the Emergency Room as identified per facility policy.

Further documentation presented by the facility identified that the information of the 03/08/04 Incident and the facility's investigation had been faxed to the Illinois Department of Public Health, Marion Regional Office. Per review of the Incident Reports maintained at the Marion Regional Office and as confirmed with office staff, no record of the 03/08/04 Incident was located.

On 03/12/04, documentation identified that R10 was seen by his physician and that no STD (Sexually Transmitted Disease) testing was recommended.

03/25/04 5:40 a.m. Staff found R10 and R14 standing in R10's doorway. R10 was bent over with pants down and R14 was holding his penis in hand. Both clients stopped when staff approached. No documentation was identified that would indicate that R10 was physically examined by staff or nursing for signs of penetration.

No further documentation was noted in R10's chart regarding further sexual incidents until 07/09/04.

Review of the Incident/Accident Report and R10's Universal Notes for 07/09/04, R10 and R14 were found in the upstairs bathroom at 7:00 a.m.. R14 was observed with his penis inserted in R10's buttocks. No documentation was identified that would indicate that R10 was sent to the

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Emergency Room after the incident as per the facility's policy and procedure. Per interview with E1 (Resident Service Director) on 10/12/04 at 2:40 p.m., E1 stated that R15 had not been sent to the Emergency Room because, "We knew sexual contact had occurred and that we didn't feel the need to do a Rape Kit."

Further documentation presented by the facility identified that this information regarding the incident of 07/09/04 and the facility's investigation had been initially faxed (fax did not go through), then mailed to the Illinois Department of Public Health, Marion Regional Office. Per review of the Incident Reports maintained at the Marion Regional Office and as confirmed with office staff, no record of the 07/09/04 Incident was located at the Marion Regional Office.

Per interview with E7 (Direct Support Person) on 10/13/04 at 4:34 p.m., E7 stated that she had never seen R10 nor R15 seek out R14. E7 stated that she thought R10 understands some things about sex, but did not understand the whole concept. E7 stated that this was also true of R15. E7 stated that she believed that R14 knows what sex is. E7 also stated that she had witnessed R14 and R10 engaged in sexual activity. E7 stated that about two to three months ago, she saw R10 and R14 with their pants down, but was unsure of how far they actually went. E7 stated that she had documented the incident and had called the Resident Service Director (E1).

4) Per review of the Admission Information, R14 is a 69 year old male who functions at a moderate level of mental retardation which was changed to severe level of mental retardation in October of 2002. During the survey dates, R14 was observed to ambulate without assistance and to engage in conversation with staff, clients and the surveyors. Interview with E5 (Food Service Supervisor/Direct Support Person) on 10/13/04 at 9:59 a.m., E5 stated that R14 knows and understands right from wrong but does not fully understand the importance of safe sex.

Review of the Incident/Accident Reports identified that R14 had been found engaged in anal intercourse with R10 on 03/08/04 and 07/09/04. Further review of R14's Universal Progress Notes identified that R14 had been found engaged in sexual acts with R10 on 12/21/03, 12/22/03, 01/04/04, 01/06/04, 01/10/04, 01/13/04, 01/14/04, 01/19/04, 03/08/04, 03/25/04 and 07/09/04, and engaged in sexual acts with R15 on 12/28/03, 01/01/04, 01/06/04, 02/21/04, and 05/05/04. Examples of the documentation in the Universal Progress Notes include:

12/22/03 "R14's Inappropriate Sexual Behavior program" reintroduced after incident of 12/21 and 12/22/03.

12/28/03 1:55 (a.m. or p.m. not specified) "Staff witness R15 and R14 in the bathroom. R14 had he (his) zipper down and sitting on towlit (toilet) and R15 was on his knees with his pants down. Did not see no contactt (contact)...".

01/04/04 6:45 a.m. This staff went to get the guys up for breakfast. And was walking down the hall. R14 and R15 was in the bathroom at the same time. R15 had his shorts down and R14 was standing (in) front of him. This staff asked R14 to lave (leave) the bathroom and he did so.

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About 20 minutes latter (later) this staff went back up stares (stairs) to make the bed's. R14 was in the bathroom with R10. He had his underware (underwear) down and R14 was standing behind R10. Contact (was not made as this staff knowes (knows)." No documentation was identified that would indicate that R15 or R10 were physically examined by staff or nursing for signs of penetration, or that R15 or R10 were sent to the Emergency Room, or that the Illinois Department of Public Health was notified.

01/10/04 "This a.m. 6:45 this staff went upstairs to get the residents up for the day. I caught R14 and R10 in the bathroom with R10's underpants dwon (down) and R14 was standing behind R10. There was contatt (contact) betweten (between) them." No documentation was identified that would indicate that R10 was physically examined by staff or nursing for signs of penetration.

01/13/04 (No time specified.) "... R14 and R10 was in the bathroom together, I did no (not) see no contatt (contact)."

01/14/04 (No time specified.) "I went to get the resident up and R10 came out of the bathroom pull (pulling) up his underwear and R14 came out with his penis haging (hanging) out. He put it up when he saw me. I did not see no contttat (contact)."

No documentation was identified for 01/10, 01/13 or for 01/14/04 that would indicate that R15 or R10 were physically examined by staff or nursing for signs of penetration, or that R15 or R10 were sent to the Emergency Room, or that the Illinois Department of Public Health was notified.

Further documentation identified that a meeting was held on 03/08/04 to discuss the incident of 03/08/04 and to modify R14's behavior program.

Interview with E2 (Nurse Consultant) on 10/14/04 at 8:50 a.m., E2 stated that she could not give the surveyor the specific date of change, but the prior method had identified that if R14 awakens early, R14 would be asked to go back to bed or to go downstairs. The current program identifies that R14 is to be asked to go down stairs and is not given the option to go back to bed. Review of the programs dated 12/23/03, 03/08/04 and 09/01/04 identified that R14's remained on 15-minute checks and that the level of checks were not increased to assist in monitoring R14's inappropriate sexual behavior.

05/05/04 (No time specified.) "Staff went upstairs, when passing R14's room, staff noticed R15 et (and) R14 standing in the room, R14 et R15 had their pants down. R15 was standing in front of R14 . It appeared like R14 was getting ready to engage in anal intercourse. Staff told him to stop et both R15 et R14 pulled up their pants...".

Per file review, R14 has a behavior program in place, dated 09/01/04 to address inappropriate sexual behavior. The behavior program identifies that, "R14 often masturbates in other peer's room or in the bathroom with doors open. He has shown a desire to interact with other male

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peers sexually. Two other peers have been identified to have an interest with R14. Both are lower functioning than R14. One has been seen willingly visiting R14's room and the other has allowed R14 to enter his room. Neither have shown a negative reaction to this interaction. However it can not be determined with certain validity that the acts have been non consensual...".

Documentation for the baseline data identified that R14 had had 0 incidents in June 2004, 1 incident in July 2004, and 0 incidents in August 2004.

II. Review of the program's methods identified :

1. R14 will participate in Sex Education class one time a month at the facility (name of the facility stated) and when offered at the day training site (name of Day Training site stated).

2. R14 attends (name of Day Training site stated) Monday - Friday. At approximately 3:00 p.m., R14 arrives at the facility (name of the facility stated). At that time R14 will be encouraged to participate in a structured activity of his choice.

3. When R14 is upstairs, staff should check on R14's location every 15 minutes until he goes to sleep. Staff should encourage R14 to stay downstairs, and stay up as late as possible. He typically goes to bed as early as 8:30. When he does this, he often is awake as early as midnight or 1:00 a.m.. This can be a potential problem. If R14 awakens this early, he should immediately be asked to come downstairs and watch television.

4. During the afternoon or evening, if R14 goes upstairs staff should note what other peers are downstairs.

5. If R14 is seen masturbating in his room, staff should close the door and allow him his privacy.

6. If R14 is seen in the bathroom or in another peer's room, R14 should immediately be asked to step out. He has the option of either going to his room or downstairs.

7. If R14 chooses to go to his room, staff should pull the door shut and allow him privacy. Staff should wait upstairs for 15 minutes and recheck the other resident rooms and the bathrooms every 5 minutes until R14 comes downstairs.

8. When R14 participates in the Sexual Education Class, he should be given verbal praise and will earn a trip out to eat with his girlfriend.

9. R14 is currently having an increase of sexual urges. Staff should continue to be open and honest with R14 regarding the increase in urges and try to direct them towards "self fulfillment" and stress the value of maintaining a boyfriend girlfriend relationship.

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10. If R14 is involved sexually with another peer, all precautions listed in policy and procedure should be taken. The RSD should be notified immediately.

11. Although R14 is higher functioning, he is not his own guardian, and he often is "interested" in 2 lower functioning males at facility (name of the facility stated). Close monitoring of this situation is necessary, due to the difficulty of determining if acts have been consensual.

12. R14 will be rewarded with an extra shopping trip, a special trip out for an edible treat, or a small tangible reward each week that he does not exhibit any inappropriate sexual behavior.

Further review of the behavior program under the section marked Intrusive Procedures Utilized identified, "not allowed in peer's bedrooms. Will be transferred if he commits any sexual aggression toward another person and will withhold community trips. R14 will be denied sexual interaction with some residents. Thus far all interaction has been with lower functioning peers whom the facility (name of the facility stated) is trying to protect....".

Further review identified that R14's behavior program had been revised on 03/08/04, 03/23/04, 03/25/04 and 08/18/04. Review of the programs dated 12/23/03, 03/08/04 and 09/01/04 identified that R14's remained on 15 minute checks and that the level of checks were not increased to assist in monitoring R14's inappropriate sexual behavior.

Under the section of the behavior program identified as "Consumer Comments" documentation stated, "R14 agrees with program, however at times, he has openly expressed his desire to continue this activity especially when caught or confronted by staff when the behavior occurs. Other times he has agreed to stop sexual behavior with male peers and expresses a desire to maintain an interest in females. After periods of time, R14 often verbalizes his absence of sexual behaviors and appears to seek confirmation and praise."

E4 was interviewed on 10/13/04 at 1:45 p.m. and stated that she had never seen R15 nor R10 seek R14 out. E4 stated that R15 will do anything you tell him to do and that R15 is nonverbal. E4 further stated that R14 is not as severe as R15 and R10. E4 stated that you can engage in conversation with R14, but you can not with R15 and R10. E4 also stated that she does the sex education classes twice a month. E4 stated, "After the incident with R14 and R15, to hear R14 talk, he doesn't think it's wrong." E4 stated that she did not think that the clients had any type of sexuality assessment, and was pretty sure that R14 did not have one.

File review did not identify that sexuality assessment had been completed for R14, nor R10 or R15. E2 confirmed during the Daily Status Meeting on 10/13/04 4:55 p.m., that no sexuality assessment were on file for R10, R15, and or R14.

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350.620a) 350.700a) 350.1230c)d)2) 350.3240a)d)f) (Cont.)	Per interview with E6 (Direct Support Person) on 10/13/04 at 9:50 a.m., E6 stated, "Tuesday of last week, I found R14 in the bathroom with R10. R14 was behind R10 and had pajamas on." E6 stated that this had occurred at approximately about, "10 minutes after 6:00 a.m.". E6 stated that he did not tell E1(RSD) or anyone about the incident. E6 confirmed after review of R14's Universal Progress Notes that he had forgotten to document this incident. During this interview, E6 stated that he had never seen R10 nor R15 seek out R14.

(A)

CH:jb/LINCOLN SQUARE (10-26-04)