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

ORCHARD COURT
Facility Name

0040970
I.D. Number

1430 STATE ROUTE 127 SOUTH, JONESBORO, ILLINOIS 62952
Address

Reviewed By

10/19/05
Date of Survey

Incident Report Investigation of 9/7/05
Type of Survey

Surveyed By

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 of 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):

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350.670e)
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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.

Prior to employing any individual in a position that requires a State license, the facility shall contact the Illinois Department of Professional Regulation to verify that the individual's license is active. A copy of the license shall be placed in the individual's personnel file.

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

A FACILIY 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)

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)

Based on observation, interview, file review and per review of the facility's policies and procedures, 2 of 14 individuals of the facility (R2 and R3) have been subjected to nonconsensual client to client sexual advances from R1 and the facility has neglected to implement their own policies and procedures that ensures a system which protects the individuals from mistreatment, neglect or abuse, having the potential to impact all clients of the facility (R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14 and R15), as evidenced by:

1)Per review of the Medications and Treatments sheet (Physician Orders), R1 is a 33 year old male who functions at a moderate level of mental retardation and has diagnosis of autism. R1 was observed during the survey dates ambulating independently at the facility and was not observed to verbally communicate with staff and or other individuals of the facility. During the survey dates, the surveyor did not observe that additional staff monitoring was in place for R1 during the morning and evening routines at the facility.

On 08/30/05, R1 was found twice by staff attempting to undress R2 at 3:00 A.M. and the facility staff failed to document these incidents on the facility's "Preliminary Report" as per facility policy. As a result of this failure to document these incidents on a Preliminary Report, the facility failed to investigate these two incidents and to institute a sufficient monitoring system to protect R2 from R1 and prevent further reoccurrence.

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Per review of the facility's policies and procedures for Incident Reporting, documentation identifies, "For purposes of the policy an "incident" shall be defined as any unusual occurrence that threatens or could threaten the safety or well being of one or more residents or is detrimental to one or more residents, whether or not actual injury occurs." Under the section of the policy for procedure, documentation identified that, "Staff will initiate a Preliminary Report and/or an Incident Report of each incident."

During the Incident Report Investigation of 09/07/05, the surveyor noted that staff had documented an incident on a behavior sheet located in the staff's program documentation book. Documentation identified that on, "08/30/05 R1 was caught 2 times with R2 yelling and clothes down around ankles."

Per telephone interview with E5 (Third Shift Direct Care Staff) on 10/13/05 at 11:30 A.M., E5 confirmed that she had worked on 08/30/05 and had written the 08/30/05 documentation regarding R1 and R2. E5 stated, "I heard noises in the hallway down on the south east end, down by the laundry room. R2 was down on the floor with his pajama pants and underwear down around his ankles. R1 was trying to pull his (R2's) shirt off. R1 was standing in front of R2 and R2 was yelling... About fifteen minutes later, I was in the dining room cleaning and heard a thud. It sounded like the toilet lid dropping and I went to check. I found R1 and R2 in the bathroom. R2 was yelling and R1 ran out of the bathroom when I came in. R2's pajama pants and underwear were down around his ankles..." During this interview, E5 confirmed that these incident had occurred between 3:00 to 3:30 A.M. and had occurred within fifteen minutes of each other. During this interview, E5 confirmed that R1 and R2's bedroom were directly across the hall from each other. E5 stated, "I positioned myself in the hallway to keep an eye on R1... I spoke with E1 (QMRP) when she came in the next morning and she told me to document..." When E5 was asked by the surveyor if she considered the incident(s) a behavior or a sexual incident, E5 stated that she considered the incidents, "sexual".

No documentation was located by the surveyor that would identify that a Preliminary Report and or an Incident Report had been completed for the 08/30/05 incident(s) as per the facility's policy. Additionally, no documentation was noted that would identify that the facility had thoroughly investigated the incident(s) that occurred on 08/30/05 until brought to the attention of the facility by the surveyor on 10/13/05.

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Per review of R1's Nurse's Notes, documentation identified that on 09/06/05, "Staff reported now that on 08/30/05 at 3:30 A.M. (Staff's initials given) noted yelling on S. (South) end in BR (bathroom). R2 (res) noted in BR with clothes to ankles. R1 in there et (and) ran to his Rm (room). No contact noted. NAI (No Apparent Injury). R1 watched closer thru noc (night) et R2 escorted to Rm. Occurred2 times. Notified E1/POC (Person On Call) @ (at) being told this et stated "staff mentioned it." Spoke with E3 (RSD (Resident Services Director-RSD) and E2 (Quality Assurance-QA) @ being told this. Neither think is sexual. NAI to either res..."

Per interview with E1 (QMRP) on 10/13/05 at 3:15 P.M., E1 stated, "Somebody told me about the 08/30/05 incident, I think it was E5... I assume it was the next day and I told her to write it up... She should have called the On Call person which I think was E2 (Quality Assurance)... I'm unsure if we took action because we didn't think that the incident was sexual... No preliminary report was done for the 08/30/05 incident and E5 should have filled out a Preliminary Report as per (the facility's) policy..." During this interview, E1 confirmed that she had not seen the documentation for the 08/30/05 incidents regarding R1 and R2. E1 also confirmed that she reviews the behavioral documentation and or non targeted behavioral documentation on a monthly basis.

On 10/14/05, the facility provided the surveyor with an investigation regarding the incident that occurred on 08/30/05 that had been completed by the facility on 10/13/05. Documentation within the investigation identified that E5 thought that the 08/30/05 incidents were part of R1's (grooming peers program) and did not think that the incident was sexual in nature.

Subsequent telephone interview with E5 on 10/17/05 at 9:10 A.M., E5 stated, "I told you that I considered the incident sexual, but that was my own personal opinion. We have been trained not to draw an opinion but deal with facts..."

Documentation of the facility's 10/13/05 investigation regarding the incidents that occurred on 08/30/05 did not identify that additional monitoring and/or safeguards were initiated after 08/30/05 to protect R2 from R1 and prevent reoccurrence.

Per review of R1's Nurse's Notes, documentation identified that on 09/03/05, "4:30P.M. at approx. (approximately) 4:05 P.M. R1 was being redirected by staff to leave another residents room where he had been several times and directed out of by staff. R1 came around corner into living room area where R4 was standing when R1 pushed R4 in chest area very hard causing R4 to fall backward hitting head on floor resulting in laceration et (and) trip to (Name of Hospital given) Emergency Room for sutures."

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Per interview with E6 (Second Shift Direct Care Staff) on 10/13/05 at 2:00 P.M., E6 stated that R1 had been following R2 quite a bit. When the surveyor had E6 review the 09/03/05 entry for R1, E6 informed the surveyor that the resident's room was R2's and that R1 had been redirected from. During this interview, E6 stated, "... R2 is generally assigned to me. I think R1 undressing R2 is considered sexual. R1's behavior program is for grooming and dressing peers , not undressing them. When I am giving showers, R1 will stand and stare at their privates..."

Per interview with E7 (Second Shift Direct Care Staff) on 10/13/05 at 2:35 P.M., E7 confirmed that R1 had been redirected from R2's bedroom on 09/03/05 after reading the 09/03/05 entry for R1. E7 stated, "I didn't work that day (is on schedule as having worked) ... R1 has been targeting R2 and R4. R1 doesn't take well to being redirected and staff have really been redirecting him because of his behavior of grooming his peers..."

No documentation was noted to identify that the facility had investigated the incident of 09/03/05 and sufficient monitoring systems to protect R2 and R4 and other individuals of the facility from R1 after that incident.

2) As a result of the facility's failure to institute a sufficient monitoring system to protect R2 and R4 and other individuals of the facility from R1, on 09/07/05, R1 was found in R2's room with an erection while holding R2's comforter and looking under the comforter while R2 was laying in bed. After this incident, the facility instituted a system of monitoring for R1 and R2, but discontinued R1's additional monitoring on 09/22/05.

Per review of the Incident Report dated 09/07/5, documentation identified that at 3:45P.M., "Res (R2) in BDRoom (Bedroom) lying down (symbol for down used) et (and) R1 in there holding comforter up. When R1 saw staff, ran out of Rm. (Room). Exited Rm and had an erection. 4:05 P.M. R2 walked on past R1 et R1 got another erection. Redirected R1 to Rm several times not follow R2 around. R2 moved to other Rm down on opposite end."

Per review of the facility's investigation (no date of completion specified), documentation identified that staff interviews had been completed regarding the Incident of 09/07/05. Review of the staff's statements identified that R2's behavior has been changing. Documentation for the Witness Statement completed for the 09/07/05 Incident by E7 identified, "...R2's behavior has changed dramatically in the last week, he has been hitting, kicking, and staying very close to staff... R2 is afraid of R1." Documentation for the Witness Statement completed for the 09/07/05 Incident by E8 (Former Staff) identified "... This has went on for about a week or two and I think R1 needs to go or get help."

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Further review of the facility's investigation identified that the facility concluded that, "... because R1's activities have been restricted, he has become more agitated and anxious and seems to be sexually attracted to R2. R1 appears to be targeting R2 for inappropriate sexual behaviors.

Per review of the facility's supervision log, R2 was placed on "Continuous Supervision" with visual observation being maintain or whereabouts known at all times after the 09/07/05 incident. On 09/09/05, R1 was placed on Continuous Supervision with checks being completed every fifteen minutes by staff. Documentation identified that on 09/22/05, R1 was discontinued from Continuous Supervision without rationale.

Per interview with E1 (QMRP) and E2 (QA) on 10/14/05 at 3:00 P.M., E1 and E2 confirmed that R1's Continuous Supervision had been discontinued on 09/22/05 because R1 had had no reported behavioral incidents. E1 stated, E3 (RSD), E2 (QA), E4 (Assistant Administrator) and myself discussed it (discontinuing R1's continuous supervision),but did not document (this decision to discontinue R1's Continuous Supervision).

3) On 09/28/05, R1 was found in the dining room of the facility attempting to grab at R3's buttocks and facility staff failed to promptly notify the administrator or designee of this incident and failed to submit a Preliminary Report regarding the incident in a timely manner. Six days after the Incident of 09/28/05, nursing staff documented the occurrence of the incident on 10/03/05, but neglected to notify the facility's QMRP. As a result, the QMRP was not aware of the incident that occurred on 09/28/05 and no modifications were made to R1's behavior treatment plan, nor were additional safeguards put into place to protect R3 and other individuals of the facility after the 09/28/05 incident.

Per review of the facility's policy and procedure for Abuse and Neglect, documentation identifies that the purpose of the policy is to, "... ensure that all residents residing at a facility owned and operated by (Company Name specified) will be free from harm. This includes but is not limited to physical, psychological, verbal, or neglect. Any form of abuse or neglect is strictly prohibited and each report of abuse will be investigated thoroughly and disciplined accordingly... The employee who becomes aware of suspected abuse or neglect shall call the administrator or designee as soon as possible and notify the administrator or designee of the alleged abuse or neglect and follow the orders of the administrator or designee..."

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Per review of R1's Nurse's Notes documentation was noted for 10/03/05 that identified, "1:45P.M. - Writer received Preliminary Report from staff (E5) on incident occurring on 09/28/05 that R1 was up at 3A along with peer R3, staff observed R1 attempting to grab peers buttocks incident report comp (completed) et faxed to E4 (Assistant Administrator) and E3 (QMRP) notified."

Per review of the Preliminary Report for 09/28/05, documentation identified that at 3:00 A.M., "R1 was following R3 around trying to grab his behind. R3 was walking very fast to get away from R1... R1 had no clothes on at this time... R1 was redirected to his room where he was watched every 15 minutes."

Per telephone interview with E5 on 10/17/05 at 9:10 A.M., E5 stated, "R3 had got up to go to the bathroom and 1 was in the dining room. I went into the kitchen and when I came out, R3 was trying to push a chair in and R1 was standing directly behind R3 touching or trying to touch his behind. R3 was naked from the waist down. R3 was trying to get away from R1... R1 had been up awhile and I had him in the dining room before the incident. After the incident, I redirected R1 back to his room and watched him closer." During this interview, E5 confirmed that R3 usually sleeps without pants and underwear.

Per review of the Routine Bed check sheet for 09/28/05 both R1's and R3's documentation for this date between the hours of 1:00 A.M. to 7:00 A.M. are blank and does not identify that fifteen minutes monitoring checks were instituted to protect R3 and the other thirteen individuals of the facility from R1 as identified per the Nurse's Notes.

Review of R1's Behavior Treatment Plan for Inappropriate Social Behavior identified that the plan had been revised on 09/26/05 and targets the behaviors of Physical Aggression, Attempting to groom peers, Exposing self, and Attempting to watch peers shower. No documentation was noted in the plan that identifies R1's level of staff supervision needed during the day and or during the morning hours when other individuals of the facility are asleep to prevent R1's sexual behaviors. Additionally no methods are identified within the behavioral interventions regarding bus riding procedures and or monitoring of R1 while at the Day Training site.

Per interview with E1 (facility QMRP) and E2 (QA) on 10/14/05 at 3:00 P.M., E1 and E2 confirmed that they were not aware of the incident that had occurred on 09/28/05 until 10/13/05. During this interview, E1 and E2 stated, that the facility's system for reporting behavioral incidents does not include notifying the QMRP but rather nursing. E1 and E2 stated, "The incidents (Preliminary Reports) go to nursing after staff complete them. Then the nurse determines if an Incident Report needs to be filled out. Nursing then notifies E4 (Assistant Administrator/Director of Nursing)." E2 confirmed that the Preliminary report for the 09/28/05 Incident was not at the facility. E2 stated, "I found the Preliminary Report (for the 09/28/05 Incident) on E4's desk. Both E1 and E2 confirmed that no investigation had been done by the facility regarding the Incident of 09/28/05. During this interview, E1 confirmed that no modifications were made to R1's behavior treatment plan, nor were additional safeguards put into place to protect R3 and other individuals of the facility after the 09/28/05 incident because she was not aware of the incident until 10/13/05.

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