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	145031	A. BUILDING ______ B. WING ______	C 03/26/2010

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HEARTLAND OF NORMAL	**510 BROADWAY NORMAL, IL 61761**

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F 225	Continued From page 7 3/19/2010 11:00 AM - R3 was taken to the hospital emergency room for a forensic evaluation for sexual assault. 3/19/2010 2:45 PM - E25, Human Resources Director notified E17 and E18 of suspension pending outcome of the abuse investigation. 3/19/2010 7:30 PM - The Administrator and the Director of Nurses were in serviced by corporate nursing vice-president on the reporting of abuse allegations, investigation of abuse allegations, and the protection of residents during abuse investigations. 3/19/2010 9:30 PM - The DON continued the investigation by conducting additional staff interviews on 6-2 shift 3 of 3 staff, on 2-10 shift 2 of 4 staff, and on 10 pm-6 am 3 of 4 staff.	F 225		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.695b)3)4) 300.695c)1)4)5) 300.695d) 300.1010h) 300.3240a) 300.3240e) Section 300.695 Contacting Local Law Enforcement b) The facility shall immediately contact local law enforcement authorities (e.g., telephoning 911 where available) in the following situations: 3) Sexual abuse of a resident by a staff member,	F9999		

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another resident, or a visitor;
4) When a crime has been committed in a facility by a person other than a resident; or
c) 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;
5) Facility investigation of the situation.
d) Facility staff shall be trained in implementing the policy developed pursuant to subsection (c).

Section 300.1010 Medical Care Policies

h) The facility shall notify the resident's physician of any accident, 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.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall

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F9999	Continued From page 9 immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act) These Regulations were not met as evidenced by: Based on interview and record review the facility failed to conduct a complete and thorough investigation into an allegation of sexual abuse. The alleged victim, R3, is one of four residents sampled for abuse/neglect. An allegation of sexual abuse was reported to the Director of Nurses (DON) by R3 and a family member. An investigatory review demonstrated critical elements were left out of the DON's probe that rendered it incomplete and ineffectual. The failure to make a good faith effort to establish the truth of the allegation and the identity of any perpetrator or perpetrators, placed R3 and all residents in the facility at risk for further sexual abuse. In addition the facility allowed the alleged perpetrators to work and have contact with all of the residents in the facility before a conclusion was reached as to the validity of the allegations. Findings include: The March 2009 Physician's Orders indicate R3 has diagnoses of Dementia, Failure To Thrive, and is a Hospice Patient. The most recent Minimum Data Set (MDS) dated 3/10/2010 shows R3 is cognitively impaired and is not ambulatory. In addition, R3 is a total two person assist for transfer and needs extensive assist for all activities of daily living. The MDS states that R3 is totally incontinent of bowel and bladder.	F9999		

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E2, Director of Nurses on 3/19/2010 at 1:15 PM indicated she is co-abuse coordinator with the Administrator. Interview with E2 at this time provided the following information:

"At approximately 12:00 PM on 3/18/2010...(R3) (in the presence of family member Z1) said to me (DON) 'last night a man touched me.' At this point I excused myself to get a witness. I said I would be right back. I got (E16) Assistant Administrator, and we brought (R3) into my office. (Z1) the family member came in as well. I said, what happened? She (R3) said 'I was woke up and his hand was where it shouldn't be.' She said his hand was on her vaginal area. I asked if he said anything to her while he was touching her down there? She (R3) said 'He didn't say anything, he done something.' She (R3) said 'you know, you know.' She wouldn't elaborate. I asked her when it happened. She said, 'it was in the night, last night.' I asked if he was white or black. She said, 'he was black.' At this point (Z1) interjected and said, 'you know his name, don't you (R3)?' (Z1) looked at (R3) and (Z1) said you know the name, the guy we were just talking about.' (R3) looked at (Z1) then at me (DON) and said (E17, Certified Nursing Assistant (CNA)), (E17), (E17), (E17)...at least five or six times... I knew (E17) was working... so I (DON) told her (R3) to stay in my office until I came back to get her. I left and went down and found (E17)...I told him I needed to see him right now. Myself and (E16) escorted him to the Assistant Director of Nursing's Office. I told him an allegation of sexual abuse had been levied against him and told him I needed to ask him some questions."

The DON then stated she asked E17 some

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questions, suspended him, escorted him to get his things, and then out of the building. During E2's interview with E17, E2 became aware that another black male CNA (E18) had cared for (R3) during the night (of 3/17/2010 to morning of 3/18/2010). The DON stated she came back to her office. She stated (R3) had left her office and was in the dining room. "While (R3) was eating I (E2) interviewed some other staff and called the other black male CNA (E18) who fit the description and suspended him."

The DON went on, ..."at about 1:00 PM myself and (E16) interviewed (R3) again (without any family members present). (R3) described more in depth what happened to her. She said 'last night, early morning a tall heavy black man took care of me...' I asked how? She (R3) said '...he done things he shouldn't have down below. He took care of me in his way.' I said, did he have sex with you? She said, 'he had sex with me.' ...I said, did he have sex with you with his hands or with his penis? She said, 'he touched me. I was on my side and I could feel it...' I asked if she had ever seen him before. She said she had seen him before, he works here. I asked her if he had ever done anything like that to her before. She said he had never done anything before to me. I asked if anyone else had taken care of her she said, 'no, only my husband.' (The DON stated, I think she meant 'taken care of'' was another way to say had sex with her) ...The DON said (R3) told her that it happened when it was dark out. She then stated she asked a few more questions and concluded the interview. The DON stated that after lunch, staff laid (R3) down and she (DON) did a head to toe examination of R3. The DON also stated she had interviewed some of the interviewable residents in the building about

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F9999	Continued From page 12 their care and had physically examined the cognitively impaired residents on R3's hallway for signs of abuse. She stated she did not find any other problems. The Director of Nurses confirmed she was not a forensics trained nurse and had no experience in identifying sexual assault by examination. The DON then acknowledged that she finished her investigation at about 5:30 PM on 3/18/2010. An interview with R3 on 3/24/2010 at 11:00 AM confirmed the allegation she had given to the Director of Nurses on 3/18/2010. R3 confirmed she believed she was sexually assaulted by a male staff member. On 3/19/2010 at 3:00 PM when asked if she had called R3's Physician, or sent R3 to the Emergency Room on 3/18/2010, the DON stated she had not. She also said she had failed to notify the Police until 3/19/2010 at 10:15 AM. In addition no Physician was notified until the morning of 3/19/2010 at 8:45 AM when R3 was seen by the Medical Director at the facility. R3 was not sent to the hospital until after being seen by the Physician on 3/19/2010. Staffing sheets dated 3/17/2010 and 3/18/2010 and interview with the DON on 3/23/2010 at 1:00 PM confirmed that the DON failed to interview 3 of 3 nursing staff from day shift on 3/18/2010, two of four staff from the afternoon shift on 3/18/2010, and three of four nursing staff who worked the night shift on 3/17/10 to 3/18/10. The DON confirmed even though they might have provided valuable information she had deemed the investigation was concluded before she interviewed these staff on 3/19/2010. In addition the DON indicated she failed to investigate and	F9999		

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find or to interview other possible witnesses including other family members (a granddaughter who visits) and a friend (Z2)who visited regularly.

Time keeping records for the two CNAs considered to be the alleged perpetrators shows the following:

E18 CNA was allowed to come back to work at 10:16 PM on the night of 3/18/2010. He clocked out at 6:31 AM on 3/19/2010. The record indicates he worked seven hours and forty-two minutes before the incomplete sexual assault investigation was reopened. E17 clocked in at 5:48 AM on 3/19/2010 and clocked out at 2:11 PM on 3/19/2010. The record shows E17 worked seven hours and fifty-seven minutes before the incomplete sexual assault investigation was reopened.

The facility abuse policy states, "...Investigate...The facility must have evidence that all alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in progress... Once reported , the center should conduct a timely, thorough and objective investigation of all allegations of abuse...Reporting...The center must ensure that all alleged violations involving mistreatment, neglect, or abuse...are reported immediately to the Administrator of the center and to other officials in accordance with state law..."

E1, Administrator stated on 3/23/2010 at 10:00 AM that after an abuse allegation that involves staff to resident abuse, the residents are protected from further abuse by the suspension of any alleged perpetrators. E1 stated any

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F9999	Continued From page 14 accused staff are not allowed to come back to work until a complete and thorough investigation is done. E1 stated the facility had reopened the investigation into the abuse of R3 in the afternoon of 3/19/2010 and had re-suspended both E17 and E18 at approximately 2:45 PM on 3/19/2010. (A)	F9999		