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F 000	INITIAL COMMENTS Complaint investigation #1122489/IL54103-F223, F226. Complaint investigation #1122493/IL54109-F203. A partial extended survey was conducted.	F 000		
F 203 SS=D	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days.	F 203		9/2/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 203	Continued From page 1 The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide a 30 day notice of intent to discharge and failed to provide physician documentation of need for immediate discharge for one resident of four discharged residents (R3), in a sample of six. Findings include: R3's Resident Admission Information sheet dated 02/04/11 indicates that R3 was admitted on 09/21/10. R3's Physician Orders sheet (POS) indicates that	F 203		

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F 203	Continued From page 2 R3 has a diagnosis of "Altered mental state" and "End stage renal failure (with dialysis orders)." Z3, R3's daughter and power of attorney (POA), on 08/15/11 in a phone call at 12:05 P.M., stated that on 08/11/11, "The nursing home freaked out because some other male resident had sex with some other old lady and that guy got discharged. (R3) had touched some lady's thigh, but he didn't grope her. (The facility) sent (R3) to the emergency room and wouldn't take him back. (E19, Medical Director and R3's attending physician) saw us (R3 and Z3) at the hospital but it wasn't official." Z3 went on to verbally elaborate the inconvenience to herself and R3 due to associated medical issues and issues of transportation that R3 being involuntarily discharged had incurred. Z3 stated that she did not believe she received all discharge papers from the facility that should have been given to her. R3's Social Service Progress Notes, completed by E17, Social Services Director, indicates on notes from 10/07/10 through 08/11/11 multiple discussions with R3 and Z3 regarding his inappropriate touching and kissing of both staff and other female residents, as well as using inappropriate language. Notes on 08/10/11 indicate that Z3 refused to allow a psychoactive medication to be administered to R3 to assist with behavioral management. On 08/16/11 at 3 P.M., E18, Assistant Administrator, stated that R3 was given an "Emergency discharge" on 08/11/11 due to R3's continuing , socially inappropriate behaviors that could have potentially endangered other residents	F 203		

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and the refusal by R3's family to allow psychoactive medications ordered for R3 to moderate those same behaviors. Upon initial request to E18 on 08/16/11 for the facility's discharge policy/procedures, E18 stated that she wasn't sure there was one. On 08/17/11 at 10:17 A.M. E18 provided a copy of the facility's "Discharge policy." The policy provided had no indications of, nor qualifications for what constituted an "emergency discharge." There were no indications in this policy that a 30 day notice of intent to transfer or discharge any resident must be given, nor were there any indications provided for physician ordered, discharge documentation requirements/needs.

On 08/15/11 in a phone conversation at 11:20 A.M., E19, Medical Director, stated that the facility, "Has not been able to provide the care (R3) needs and he is kissing and touching other residents. (R3's) family was not being cooperative with recommended medication changes, kept refusing them." E19 also said, "I did go to the local emergency room where (R3) was sent and discussed with the doctor there why we (the facility) could not accept (R3) back as a resident. I also explained this to (R3's) family." When E19 was asked what he explained to R3 and his family, E19 said, "(R3's) behaviors put other resident's at risk and the family's refusal to let (R3) take prescribed medications to decrease his socially inappropriate behaviors made the facility unable to appropriately treat R3." When E19 was asked why he did not write this information in the "Physician's Progress Notes" section of R3's chart or make it a part of R3's discharge order, E19 replied, "I was anticipating the psychiatrist to write a specific discharge note

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F 203	Continued From page 4 but I will happily come in and make one. (R3) most definitely needs help but we (facility) cannot provide it or allow his inappropriate behaviors to continue." On 08/15/11, E18 provided copies of "Notice of Involuntary Transfer or Discharge and Opportunity for Hearing" dated 08/11/11 and signed by Z3, R3's POA, as being received by them on 08/11/11. R3 was discharged that same day, 08/11/11.	F 203		
F 223 SS=K	483.13(b), 483.13(b)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on interview, observation and record review, the facility failed to immediately identify and stop a situation of occurring sexual assault for one of six residents (R2) reviewed for sexual assault in the sample of six. R2 was sexually assaulted by R1. R2 suffered physical trauma to her vaginal and rectal areas. This failure had the potential to affect nineteen other confused, female residents in the supplemental sample (R5, R7, R8 through R24). Findings include:	F 223		9/2/11

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E5, Certified Nurses Aide (CNA), on 08/11/11 at 2:35 P.M., stated that she entered R2's room between 9:30 P.M. to 9:45 P.M. and saw an unidentified man (later identified as R1) laying on top of R2. E5 related that both the unidentified man and R2 had their pants "Half way down." E5 stated she was uncertain if R2 had some sort of conjugal privileges and R2 was "Laughing, sort of, and said (to E5) to close the door." E5 stated that she closed R2's room door and went to tell two other CNAs, E6 and E7. All three CNAs then went back to R2's room and found R1 laying in bed next to R2 with his pants up. E5 stated E7 directed R1 out of R2's room and the incident was reported to E29, Registered Nurse (RN).

R2's Resident Admission Information dated 06/02/11 indicates that R2 is widowed. E5 stated on 08/11/11 at 2:35 P.M. she was not aware that R2 was widowed. E5 verbally related she was also not aware that there were no facility consensual sexual activity contracts in place on 08/08/11.

E13's, Licensed Practical Nurse (LPN), police interview dated 08/08/11, was provided by Z1, Detective with the local police municipality. E13 stated E7, CNA, reported that R1 had been found "On top of (R2) and moving up and down. The top of (R2's) head was banging against the head of the bed."

E29's, Registered Nurse (RN), police interview dated 08/08/11, documents that E5, E6, and E7 (All CNA's) informed E29 that (R1) and (R2) were "Actively engaging in the act of intercourse." This document also indicates that E29 stated that R1 was witnessed "By all three CNAs (E5, E6, and

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E7)...(R1) in (R2's) room...on top of (R2) on her bed...(R1's) penis was noted to be protruding out of the opening of his pajamas and that (R1) was laying on top of (R2) whose pants and (incontinence) briefs were pulled down to her knees...observed (R1) in thrusting motion while on top of (R2)."

E7, CNA, stated on 08/16/11 at 2:37 P.M. that E29 was informed "Within a minute after (E5) told us about (R2)." E7 stated that when she saw R1 in R2's room, "I knew he wasn't supposed to be there. I told (R1) to leave." E7 stated that R1 went to his room which was across the hallway from R2's room and that she stood outside R1's doorway until "The police arrived before the ambulances did." The local police Incident/Investigation indicates that the police arrived at the facility on 08/08/11 at 10:57 P.M.

Both E6 and E7, CNAs, on 08/15/11 at 2:30 P.M. and 08/16/11 at 2:37 P.M., respectively, stated that upon being informed by E5 on 08/08/11 of what she had just witnessed, they realized that was not right. Both E6 and E7 stated that within a minute of being informed, all three (E5, E6, and E7) went to R2's room.

On 08/15/11 at 2:30 P.M. E6, CNA, stated that upon arriving at R2's room and opening the door, R1 was laying beside R2 with his pants fully on and up but R2 's pants were "Half way down." E6 stated "(R1) wasn't supposed to be there...(R1) was told to leave and he walked out of the room." E6 stated that E7 informed E29, RN, of this incident.

E8, the nurse manager, on 08/11/11 at 12:30

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P.M., stated that she had been called "Around 10 P.M.," on 08/08/11 about the incident between R1 and R2. E8 stated she had spoken to E19, Medical Director, and received orders for R1 to be sent out for a psychiatric evaluation and R2 for an emergency, physical evaluation. E8 stated she had also notified E1, Administrator, E2, Director of Nurses (DON), E18, Assistant Administrator, and "the nurse consultant," all around that time. E8 stated that E13, Licensed Practical Nurse (LPN), had called the local ambulance dispatch to arrange transport for R1 and R2.

R2's Patient Transfer and Medical Record completed by E13 on 08/08/11, indicates that R2 was transported to a local emergency room on 08/08/11 with "Complaints of backside/bottom hurting after sexual assault by other resident... (R2) witnessed being sexually abused by a male resident."

R2's emergency room (ER) record of 08/08/11-08/09/11, indicates that Z6, a local hospital's emergency room physician, completed a physical exam on R2 on 08/09/11 at 2:07 A.M. This physical exam indicates that in a sexual trauma kit report that R2 had "Evidence of perianal (around the anus) and vulva (vagina) trauma (injury) with petechia (Small red dots often arising on skin or other tissue after frictional rubbing) and skin excoriation (abrasions)." The ER report of the same date indicates, "Vulva and perineum (area between the vulva and anus) and perianal skin tears, erythematous (red and swollen)- small areas of excoriation skin tears at ("entioileus", sic., term not found and Z5, ER Manager, upon questioning, was not familiar with

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the term) and multiple small abrasions. (R2) unable to tolerate speculum insertion (a device used to open the vaginal vault to inspection). Rape kit was sealed. No labs resulted."

E5, CNA, stated on 08/11/11 at 2:35 P.M. that E7, CNA, gave R2 a shower after the incident with R1 on 08/08/11. E5 explained that 08/08/11 was R2's "Shower day" and "(E7) said we (E5 and another CNA, E6) should give (R2) a shower 'cause we didn't know if (R1) got inside (R2) or not".

On 08/15/11 at 2:30 P.M., E6, CNA, stated that R2 had been given a shower after the incident with R1 on 08/08/11. E6 denied being directed by any other staff to shower R2. E6 stated that R2 had earlier that day refused to take shower on R2's "Shower day, " and usually if R2 was instructed later to go take a shower, with staff leading, "(R2) would take her shower." E6 implied that after the incident with R1 she felt R2 would appreciate being cleaned up.

E7, on 08/16/11 at 2:37 P.M., stated, in regards to giving R2 a shower on 08/08/11 after incident with R1, "I feel bad now, but it was (R2's) shower night. I didn't know anything about washing away evidence." E7 stated she could not remember ever receiving any training from the facility about any specialized care that needed to be provided to alleged sexual assault victims, "Not till I talked to the police (on 08/08/11)." These statements conflict with E7's statements that she had stood outside R1's doorway until the police arrived on 08/08/11.

R1's Resident Admission Information sheet dated

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06/02/11, indicates R1 was admitted on this same date.

R1's Admission Assessment, dated 06/02/11, indicates his "Mental Status" as "Alert, Oriented (to) name, place and year."

R1's Nurses' Notes dated 06/02/11 at 1 P.M. indicate that he "Ambulates with rolling walker." Another "Nurses' Note" dated 06/03/11 at 9:30 P.M. indicates that R1 is "Up ad lib (as per his own desire)." Yet another "Nurses' Note" dated 06/04/11 at 1:18 P.M. indicates that R1 "Walks/ambulates freely."

R1's Psychosocial Assessment & Social History, dated 06/07/11 and completed by E17, Social Services Director, indicates that R1 was placed at the highest level ("Level 1") of mental functioning with "Modified independence" of decision making.

R1's initial Minimum Data Sets (MDS), dated 06/15/11, indicates that R1 has no identified cognitive or behavior problems.

E11, Certified Nurses Aide (CNA), on 08/11/11 at 12:05 P.M., described R1 as "Well oriented, could carry on a conversation." E11 further described an incident that occurred between her and R1 "The week-end before last," when R1 had attempted to hug E11 while she was providing nail care. E11 stated she had "Written it up as a behavior (incident) and informed the nurse," but could not recall which nurse that was.

E12, CNA, stated on 08/11/11 at 12:20 P.M., "(R1), when he first came here, he seemed better oriented. Then he started complaining a lot about

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room mates and kept wanting room changes. (R1) Sat out in front (lobby) and greeted (staff) as we came into work. I now wonder, with his room changes, about how he seemed to be getting closer to the women's end of the hallway. (R1) started out at the end of the hall where there is all men residents."

R2's Resident Admission Information sheet dated 05/06/11, indicates R2 was admitted on this same date.

R2's Admission Assessment, dated 06/02/11, indicates her "Mental Status" as "Alert," but only "Oriented (to) name." This same area also includes that R2 was assessed as "Forgetful" and "Confused."

R2's Nurses' Notes dated 05/06/11 at 5:30 P.M. indicate that she was "Oriented to staff and call light. (R2) Is able to use call light but does not always remember." Included in this same note is that R2's "Son states (R2) does not eat, bathe or change clothes at home. States (R2) will sleep for days at a time, Safety is a major concern at this time...Encouraged staff to check on (R2) frequently."

R2's Psychosocial Assessment & Social History, dated 05/09/11 was completed by E17, Social Service Director. This form indicates that R2's memory and Cognitive skills are "Moderately impaired."

R2's Assessment For Residents At Risk For Incidents, dated 05/10/11 and completed by E17, indicate that R2's admitting diagnosis was Dementia. This form also indicates that R2

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requires verbal cues to accomplish activities of daily living, did not know the current season or date and was also unable to process two, simple decision making questions. This assessment indicates that R2 was assessed as not being sexually active. This form further indicates that R2's mental status is "Confused" and places R2 at "Moderate Risk- can sometimes make needs known. Individual safety care plan needed at this time."

R2's only two care plans (both dated 05/16/11) that address specific safety issues are: "Resident has exit seeking behaviors" and "Resident at risk for falls." None of R2's care plans have any specific time and frequency of when observations should be done other than listed approaches such as "Monitor and report changes in cognition" and "Close supervision."

E4, Rehabilitation Assistant/Certified Nurses Aide (RA/CNA), stated on 08/11/11 at 11:50 A.M., that she knew R2 and verbally described her as "Very confused. A lot of the times (R2) needed re-direction, told what time of day it was, where the dining room was. (R2 is) Generally a quiet person. Mostly wanted to eat and go back to bed." E4 denied ever observing any sexual behavior from R2.

E11, Certified Nurses Aide (CNA), on 08/11/11 at 12:05 P.M., described R2 as "Very confused." E11 stressed a vocal intonation on the word "Very." E11 went on to say, "We would wake (R2) up and she wouldn't know where she was, what time it was, who I was. (R2) Could take herself to the bathroom but had to be reminded to go. You could tell (R2) something and five

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minutes later you'd have to remind her again. (R2) was somewhat stand-offish (uncomfortable) with even having her pants pulled down when we (staff) were providing care."

E12, CNA, stated on 08/11/11 at 12:20 P.M., "(R2) was nice, confused- didn't know where her own room was, didn't know which way to go. I do not believe (R2) could make any good decisions, just too confused."

E8, Nurse Manager, stated on 08/11/11 at 12:30 P.M., that (R2) was "Alert but was confused. (R2) Needed a lot of directing."

E14, Licensed Practical Nurse (LPN), stated on 08/11/11 at 2:10 P.M. that she knew of, and had interacted with, R2 and that, "(R2) Was confused. Could be sitting in Dining room asking what time it was and when breakfast was, even when her breakfast tray was on the table. (R2) roamed the halls at times looking for her 'apartment,' had to be physically re-directed often."

E10, Registered Nurse (RN), stated on 08/15/11 at 12:32 P.M. that she knew R2 "Very well." E10 described R2 as "Totally confused. Always asked where the dining room was, always after eating wanted to go back to her room but couldn't remember how (to get there) or what her room number was. (R2) Always asked on a daily basis what medications she was receiving. (R2) was very sweet, very passive. A perfect victim, actually."

On 08/11/11 at 1:15 P.M. R2 stated she did not know where she was or how long she had been at that particular facility. R2 stated she did not

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remember why she was in the current facility. R2 stated she did not remember any incident involving a man on 08/08/11 and stated, "I don't remember any part of that." R2 did not remember going to or being in the hospital emergency room on 08/08/11, "For anything." R2 was unable to state time of day or what day it was. R2 was soft-spoken, smiled frequently and was pleasantly mannered.

On 08/22/11 at 10:39 A.M., E18, Assistant Administrator, provided a resident roster identifying nineteen residents as female and confused (R5, R7, R8 through R24).

On 08/17/11 at 9 A.M., E18, Assistant Administrator, stated that the facility had contracted with residents who wished to be able to participate in consensual sexual behavior in the past. E18 stated that residents could sign an agreement of this sort through Social Services department. E18 stated that there were no residents with a consensual sexual behavior contract during the time of the incident between R1 and R2 on 08/08/11. E18 stated that she couldn't remember a contract having been done, except one, "A long time ago." E18 stated that staff would be made aware of any residents with a consensual sexual behavior contract through shift reports if any were done. When asked for a copy of the facility's policy on consensual sexual behavior contracts and procedure for informing staff, E18 stated, "I don't think there is one." The facility did not provide such, either.

Z1, Detective with the local police municipality, stated that R1 was arrested on 08/08/11 at the facility and taken to jail. Z1 further stated that R1

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F 223	Continued From page 14 was to be charged with both Criminal Sexual Abuse, "A felony class charge.," and "Aggravated Sexual Abuse of a female over 60 years old." This failure resulted in an Immediate Jeopardy situation. The Immediate Jeopardy situation was identified on 08/17/11. The Immediate Jeopardy was determined to have begun on 08/08/11, when the facility failed to immediately stop an observed, non-consensual sex act between R1 and R2 as it was occurring. Both E1, Administrator, and E18, Assistant Administrator, were informed of the Immediate Jeopardy on 08/17/11 at 9:02 A.M. The immediacy of the Immediate Jeopardy was removed on 08/17/11when all staff completed in-service training. The surveyor confirmed though interview, observation and record review that the facility took the following actions to remove the Immediate Jeopardy: 1. Effective 08/08/11, R1 was escorted by the local police from the facility. This was confirmed by police documents provided by Z1 on 08/11/11. 2. R2 was transferred to a local emergency room on 08/08/11 for physical evaluation after alleged sexual abuse had occurred. 3. On 08/17/11, the facility provided In-Service training to all facility staff in the following: 1. The facility's Abuse policy, 2. The requirements of reporting abuse, 3. The requirements of protecting the resident and the threat immediately., 4. The seven types of abuse, 5.	F 223		

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F 223	Continued From page 15 How to identify abuse, and 6. Responsibilities when abuse is alleged. 4. On 08/17/11 the facility completed a audit of all alert and oriented residents and found no other complaints of inappropriate behavior. Confused or non-verbal residents were observed for signs of unexplained bruising, new peculiar behaviors and fearful expressions. No examples were noted in this category of residents.	F 223		
F 226 SS=F	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to have an Abuse policy that dealt with identification, prevention, and care of both perpetrator and victims of sexual abuse. This failure has the potential to effect all 73 residents. Findings include: The facility's Abuse policy indicates on page three, "V. Investigation C. Outside investigative bodies such as the local police will be contacted as directed by the administrator and in accordance with state and local law. The Administrators Responsibility Policy and Procedure for Abuse, provided by E1, Administrator on 08/18/11, indicates on page one: "Stage 2, A. 2. Report to the state agency and	F 226		9/2/11

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F 226	Continued From page 16 one or more law enforcement entities that a suspicion of a crime (as defined by the law of the applicable political subdivision) against any individual who is a resident of, or is receiving care from the facility." E1 stated that he was unaware of the state code indicating that local law enforcement were to be notified "Immediately" in similar circumstances. E1 verbally confirmed that the facility was currently licensed by the state. E1 stated that in the case of an alleged sexual abuse incident between R1 and R2 on 08/08/11, he thought that since the ambulance dispatch that had been called to transport R1 and R2 to different hospitals had already notified the police and since the police had arrived in less than two hours at the facility, the facility was not obligated to call the police. E1, Administrator, also verbally confirmed on 08/15/11 at 10 A.M. that the facility's current Abuse policy did not contain directions/procedures to address specific needs of alleged abuse victims, what to do if suspected sexual abuse is found to be actively occurring, how to ensure safety of other residents at risk from alleged perpetrator(s) and the preservation of alleged sexual abuse environment and alleged victims' person(s) for potential evidentiary sources after review by this investigator of the facility's Abuse policy in regards to an alleged sexual abuse incident between R1 and R2 on 08/08/11. (Specifics in regard to this incident can be found at F223)	F 226		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS	F9999		

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F9999	Continued From page 17 LICENSURE VIOLATIONS 300.610a) 300.615e) 300.615f) 300.695b)3) 300.1040c) 300.1210b) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information. e) In addition to the screening required by Section 2-201.5(a) of the Act and this Section, a facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act [20 ILCS 2635] for all persons 18 or older seeking admission to the facility.	F9999		

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F9999	Continued From page 18 Background checks shall be based on the resident's name, date of birth, and other identifiers as required by the Department of State Police. (Section 2-201.5(b) of the Act) f) The facility shall check for the individual's name on the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections sex registrant search page at www.idoc.state.il.us to determine if the individual is listed as a registered sex offender. 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, another resident, or a visitor. Section 300.1040 Care and Treatment of Sexual Assault Survivors. c) The facility shall take all reasonable steps to preserve evidence of the alleged sexual assault, and not to launder or dispose of the resident's clothing or bed linens until local law enforcement can determine whether they have evidentiary value, including encouraging the survivor not to change clothes or bathe, if he or she has not done so since the sexual assault. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care	F9999		

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and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These regulations are not met as evidenced by:

Based on interview and record review, the facility failed to follow its policies regarding notification of law enforcement. The facility failed to notify the police of a sexual abuse incident for one of one resident (R2) reviewed for sexual abuse from a sample of six. The facility failed to immediately identify and stop a situation of occurring sexual assault for one of six residents (R2) reviewed for sexual assault in the sample of six. The facility failed to preserve evidence of the alleged sexual assault for one of one residents (R2) reviewed for sexual abuse from a sample of six. The facility failed to request, within 24 hours, a criminal background check, an Illinois Sex Offender Registration check and an Illinois Department of Corrections sex registrant search for one of three residents (R1) reviewed for sexual abuse from a sample of six.

Findings include:

E5, Certified Nurses Aide (CNA), on 08/11/11 at

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2:35 P.M., stated that she entered R2's room between 9:30 P.M. to 9:45 P.M. and saw an unidentified man (later identified as R1) laying on top of R2. E5 related that both the unidentified man and R2 had their pants "half way down." E5 stated she was uncertain if R2 had some sort of conjugal privileges and R2 was "Laughing, sort of, and said (to E5) to close the door." E5 stated that she closed R2's room door and went to tell two other CNAs, E6 and E7. All three CNAs then went back to R2's room and found R1 laying in bed next to R2 with his pants up. E5 stated E7 directed R1 out of R2's room and the incident was reported to E29, Registered Nurse (RN).

R2's Resident Admission Information dated 06/02/11 indicates that R2 is widowed. E5 stated on 08/11/11 at 2:35 P.M. she was not aware that R2 was widowed. E5 verbally related she was also not aware that there were no facility consensual sexual activity contracts in place on 08/08/11.

E13's, Licensed Practical Nurse (LPN), police interview dated 08/08/11, was provided by Z1, Detective with the local police municipality. E13 stated E7, CNA, reported that R1 had been found "On top of (R2) and moving up and down. The top of (R2's) head was banging against the head of the bed."

E29's, Registered Nurse (RN), police interview dated 08/08/11, documents that E5, E6, and E7 (All CNA's) informed E29 that (R1) and (R2) were "Actively engaging in the act of intercourse." This document also indicates that E29 stated that R1 was witnessed "By all three CNAs (E5, E6, and E7)...(R1) in (R2's) room...on top of (R2) on her

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bed...(R1's) penis was noted to be protruding out of the opening of his pajamas and that (R1) was laying on top of (R2) whose pants and (incontinence) briefs were pulled down to her knees...observed (R1) in thrusting motion while on top of (R2)."

E7, CNA, stated on 08/16/11 at 2:37 P.M. that E29 was informed, "within a minute after (E5) told us about (R2)." E7 stated that when she saw R1 in R2's room, "I knew he wasn't supposed to be there. I told (R1) to leave." E7 stated that R1 went to his room which was across the hallway from R2's room and that she stood outside R1's doorway until "the police arrived before the ambulances did." The local police Incident/Investigation indicates that the police arrived at the facility on 08/08/11 at 10:57 P.M.

Both E6 and E7, CNAs, on 08/15/11 at 2:30 P.M. and 08/16/11 at 2:37 P.M., respectively, stated that upon being informed by E5 on 08/08/11 of what she had just witnessed, they realized that was not right. Both E6 and E7 stated that within a minute of being informed, all three (E5, E6, and E7) went to R2's room.

On 08/15/11 at 2:30 P.M. E6, CNA, stated that upon arriving at R2's room and opening the door, R1 was laying beside R2 with his pants fully on and up but R2 's pants were "half way down." E6 stated "(R1) wasn't supposed to be there...(R1) was told to leave and he walked out of the room." E6 stated that E7 informed E29, RN, of this incident.

E8, the nurse manager, on 08/11/11 at 12:30 P.M., stated that she had been called "around

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10:00 P.M.," on 08/08/11 about the incident between R1 and R2. E8 stated she had spoken to E19, Medical Director, and received orders for R1 to be sent out for a psychiatric evaluation and R2 for an emergency, physical evaluation. E8 stated she had also notified E1, Administrator, E2, Director of Nurses (DON), E18, Assistant Administrator, and "the nurse consultant," all around that time. E8 stated that E13, Licensed Practical Nurse (LPN), had called the local ambulance dispatch to arrange transport for R1 and R2.

R2's Patient Transfer and Medical Record completed by E13 on 08/08/11, indicates that R2 was transported to a local emergency room on 08/08/11 with "complaints of backside/bottom hurting after sexual assault by other resident... (R2) witnessed being sexually abused by a male resident."

R2's emergency room (ER) record of 08/08/11-08/09/11, indicates that Z6, a local hospital's emergency room physician, completed a physical exam on R2 on 08/09/11 at 2:07 A.M. This physical exam indicates that in a sexual trauma kit report that R2 had "evidence of perianal (around the anus) and vulva (vagina) trauma (injury) with petechia (Small red dots often arising on skin or other tissue after frictional rubbing) and skin excoriation (abrasions)." The ER report of the same date indicates, "vulva and perineum (area between the vulva and anus) and perianal skin tears, erythematous (red and swollen)- small areas of excoriation skin tears at ("entioileus", sic., term not found and Z5, ER Manager, upon questioning, was not familiar with the term) and multiple small abrasions. (R2)

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unable to tolerate speculum insertion (a device used to open the vaginal vault to inspection). Rape kit was sealed. No labs resulted."

E5, CNA, stated on 08/11/11 at 2:35 P.M. that E7, CNA, gave R2 a shower after the incident with R1 on 08/08/11. E5 explained that 08/08/11 was R2's "Shower day" and "(E7) said we (E5 and another CNA, E6) should give (R2) a shower 'cause we didn't know if (R1) got inside (R2) or not."

On 08/15/11 at 2:30 P.M., E6, CNA, stated that R2 had been given a shower after the incident with R1 on 08/08/11. E6 denied being directed by any other staff to shower R2. E6 stated that R2 had earlier that day refused to take shower on R2's "Shower day," and usually if R2 was instructed later to go take a shower, with staff leading, "(R2) would take her shower." E6 implied that after the incident with R1 she felt R2 would appreciate being cleaned up.

E7, on 08/16/11 at 2:37 P.M., stated, in regards to giving R2 a shower on 08/08/11 after incident with R1, "I feel bad now, but it was (R2's) shower night. I didn't know anything about washing away evidence." E7 stated she could not remember ever receiving any training from the facility about any specialized care that needed to be provided to alleged sexual assault victims, "Not till I talked to the police (on 08/08/11)." These statements conflict with E7's statements that she had stood outside R1's doorway until the police arrived on 08/08/11.

R1's Resident Admission Information sheet dated 06/02/11, indicates R1 was admitted on this same

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date. R1's Admission Assessment indicates his "Mental Status" as "Alert, Oriented (to) name, place and year."

R1's Nurses' Notes dated 06/02/11 at 1:00 P.M. indicate that he "Ambulates with rolling walker." Another "Nurses' Note" dated 06/03/11 at 9:30 P.M. indicates that R1 is "Up ad lib (as per his own desire)." Yet another "Nurses' Note" dated 06/04/11 at 1:18 P.M. indicates that R1 "Walks/ambulates freely."

R1's Psychosocial Assessment & Social History, dated 06/07/11 and completed by E17, Social Services Director, indicates that R1 was placed at the highest level ("Level 1") of mental functioning with "Modified independence" of decision making.

R1's initial Minimum Data Sets (MDS), dated 06/15/11, indicates that R1 has no identified cognitive or behavior problems.

E11, Certified Nurses Aide (CNA), on 08/11/11 at 12:05 P.M., described R1 as "Well oriented, could carry on a conversation." E11 further described an incident that occurred between her and R1 "The week-end before last," when R1 had attempted to hug E11 while she was providing nail care. E11 stated she had "Written it up as a behavior (incident) and informed the nurse," but could not recall which nurse that was.

E12, CNA, stated on 08/11/11 at 12:20 P.M., "(R1), when he first came here, he seemed better oriented. Then he started complaining a lot about roommates and kept wanting room changes. (R1) Sat out in front (lobby) and greeted (staff) as we came into work. I now wonder, with his room

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changes, about how he seemed to be getting closer to the women's end of the hallway. (R1) started out at the end of the hall where there is all men residents."

R2's Resident Admission Information sheet dated 05/06/11, indicates R2 was admitted on this same date.

R2's Admission Assessment, dated 06/02/11, indicates her "Mental Status" as "Alert," but only "Oriented (to) name." This same area also includes that R2 was assessed as "Forgetful" and "Confused."

R2's Nurses' Notes dated 05/06/11 at 5:30 P.M. indicate that she was "Oriented to staff and call light. (R2) Is able to use call light but does not always remember." Included in this same note is that R2's "Son states (R2) does not eat, bathe or change clothes at home. States (R2) will sleep for days at a time, Safety is a major concern at this time...Encouraged staff to check on (R2) frequently."

R2's Psychosocial Assessment & Social History, dated 05/09/11 was completed by E17, Social Service Director. This form indicates that R2's memory and Cognitive skills are "Moderately impaired."

R2's Assessment For Residents At Risk For Incidents, dated 05/10/11 and completed by E17, indicate that R2's admitting diagnosis was Dementia. This form also indicates that R2 requires verbal cues to accomplish activities of daily living, did not know the current season or date and was also unable to process two, simple

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decision making questions. This assessment indicates that R2 was assessed as not being sexually active. This form further indicates that R2's mental status is "Confused" and places R2 at "Moderate Risk- can sometimes make needs known. Individual safety care plan needed at this time."

R2's only two care plans (both dated 05/16/11) that address specific safety issues are: "Resident has exit seeking behaviors" and "Resident at risk for falls." None of R2's care plans have any specific time and frequency of when observations should be done other than listed approaches such as "Monitor and report changes in cognition" and "Close supervision."

E4, Rehabilitation Assistant/Certified Nurses Aide (RA/CNA), stated on 08/11/11 at 11:50 A.M., that she knew R2 and verbally described her as "Very confused. A lot of the times (R2) needed re-direction, told what time of day it was, where the dining room was. (R2 is) Generally a quiet person. Mostly wanted to eat and go back to bed." E4 denied ever observing any sexual behavior from R2.

E11, Certified Nurses Aide (CNA), on 08/11/11 at 12:05 P.M., described R2 as "Very confused." E11 stressed a vocal intonation on the word "Very." E11 went on to say, "We would wake (R2) up and she wouldn't know where she was, what time it was, who I was. (R2) Could take herself to the bathroom but had to be reminded to go. You could tell (R2) something and five minutes later you'd have to remind her again. (R2) was somewhat stand-offish (uncomfortable) with even having her pants pulled down when we

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(staff) were providing care."

E12, CNA, stated on 08/11/11 at 12:20 P.M., "(R2) was nice, confused- didn't know where her own room was, didn't know which way to go. I do not believe (R2) could make any good decisions, just too confused."

E8, Nurse Manager, stated on 08/11/11 at 12:30 P.M., that (R2) was "Alert but was confused. (R2) Needed a lot of directing."

E14, Licensed Practical Nurse (LPN), stated on 08/11/11 at 2:10 P.M. that she knew of, and had interacted with, R2 and that, "(R2) Was confused. Could be sitting in Dining room asking what time it was and when breakfast was, even when her breakfast tray was on the table. (R2) roamed the halls at times looking for her 'apartment,' had to be physically re-directed often."

E10, Registered Nurse (RN), stated on 08/15/11 at 12:32 P.M. that she knew R2 "Very well." E10 described R2 as "Totally confused. Always asked where the dining room was, always after eating wanted to go back to her room but couldn't remember how (to get there) or what her room number was. (R2) Always asked on a daily basis what medications she was receiving. (R2) was very sweet, very passive. A perfect victim, actually."

On 08/11/11 at 1:15 P.M. R2 stated she did not know where she was or how long she had been at that particular facility. R2 stated she did not remember why she was in the current facility. R2 stated she did not remember any incident involving a man on 08/08/11 and stated, "I don't

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remember any part of that." R2 did not remember going to or being in the hospital emergency room on 08/08/11, "For anything." R2 was unable to state time of day or what day it was. R2 was soft-spoken, smiled frequently and was pleasantly mannered.

On 08/22/11 at 10:39 A.M., E18, Assistant Administrator, provided a resident roster identifying nineteen residents as female and confused (R5, R7, R8 through R24).

On 08/17/11 at 9 A.M., E18, Assistant Administrator, stated that the facility had contracted with residents who wished to be able to participate in consensual sexual behavior in the past. E18 stated that residents could sign an agreement of this sort through Social Services department. E18 stated that there were no residents with a consensual sexual behavior contract during the time of the incident between R1 and R2 on 08/08/11. E18 stated that she couldn't remember a contract having been done, except one, "A long time ago." E18 stated that staff would be made aware of any residents with a consensual sexual behavior contract through shift reports if any were done. When asked for a copy of the facility's policy on consensual sexual behavior contracts and procedure for informing staff, E18 stated, "I don't think there is one." The facility did not provide such, either.

Z1, Detective with the local police municipality, stated that R1 was arrested on 08/08/11 at the facility and taken to jail. Z1 further stated that R1 was to be charged with both Criminal Sexual Abuse, "A felony class charge.," and "Aggravated Sexual Abuse of a female over 60 years old."

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The facility's Abuse policy indicates on page three, "V. Investigation C. Outside investigative bodies such as the local police will be contacted as directed by the administrator and in accordance with state and local law. The "Administrators Responsibility Policy and Procedure for Abuse," provided by E1, Administrator on 08/18/11, indicates on page one: "Stage 2, A. 2. Report to the state agency and one or more law enforcement entities that a suspicion of a crime (as defined by the law of the applicable political subdivision) against any individual who is a resident of, or is receiving care from the facility."

E5, Certified Nurses Aide (CNA), on 08/11/11 at 2:35 P.M., stated that she had entered R2's room approximately between 9:30 P.M. to 9:45 P.M. and had seen an unidentified man (later identified as R1) laying on top of R2. E5 related that both the unidentified man and R2 had their pants "Half way down." E5 stated she was uncertain if R2 had some sort of conjugal privileges and R2 was "Laughing, sort of, and had said (to E5) to close the door." E5 stated that she closed R2's room door and went to tell two other CNAs, E6 and E7. All three CNAs then went back to R2's room and found R1 laying in bed next to R2 with his pants up. E5 stated E7 directed R1 out of R2's room and incident was reported to E29, Registered Nurse (RN). E5, E6 and E7 stated that they did not receive any directions to call police in their separate interviews done 08/11/11 at 2:35 P.M., 08/15/11 at 2:30 P.M. and 08/16/11 at 2:37 P.M., respectively.

E29, RN, stated on 08/16/11 at 1:58 P.M., that

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she had been the one to call E8, the nurse manager, who was on call for that evening (08/08/11) to inform her of the incident between R1 and R2. E29 stated, "No, I was not directly told to call the police."

The police documents dated 08/08/11, provided by Z1, Detective with the local police municipality, indicates in it's Reporting Officer Narrative that E29 had asked E8, the nurse manager, "If she (E29) should call the police and (E8) told (E29) not to worry about calling the police at that time (08/08/11)."

E8, the nurse manager, on 08/11/11 at 12:30 P.M., stated that she had been called "Around 10 P.M.," on 08/08/11 of the incident between R1 and R2. E8 stated she had spoken to E19, Medical Director, and received orders for R1 to be sent out for a psychiatric evaluation and R2 for an emergency, physical evaluation. E8 stated she had also notified E1, Administrator, E2, Director of Nurses (DON), E18, Assistant Administrator, and "the nurse consultant," all around that time. E8 stated that E13, Licensed Practical Nurse (LPN), had called the local ambulance dispatch to arrange transport for R1 and R2. E8 stated she learned later that the ambulance dispatch had "Called the police because of the description of the incident between R1 and R2," but that she, herself, had not called the police.

E13, LPN, on 08/15/11 at 3:01 P.M., stated she had been present on 08/08/11 during the time of the incident between R1 and R2. E13 stated that E29 had called E1, the Administrator, on 08/08/11 after the incident with R1 and R2 had been

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discovered. E13 stated she had been told by E29 that E1, Administrator, had told E29 not to call the police because the ambulance dispatch had already called them and had arrived "Before even the ambulances got (to the facility)."

E13's police interview dated 08/08/11, indicates that E13 stated that E7 had reported to E13 that R1 had been found "On top of (R2) and moving up and down. The top of (R2's) head was banging against the head of the bed."

E29's, Registered Nurse (RN), police interview dated 08/08/11, provided by Z1, Detective with the local police municipality, indicates that E5, E6, and E7 had all informed E29 that (R1) and (R2) were "Actively engaging in the act of intercourse." This document also indicates that E29 stated that R1 was witnessed "By all three CNAs (E5, E6, and E7)...(R1) in (R2's) room...on top of (R2) on her bed...(R1's) penis was noted to be protruding out of the opening of his pajamas and that (R1) was laying on top of (R2) whose pants and (incontinence) briefs were pulled down to her knees...observed (R1) in thrusting motion while on top of (R2)."

E2, DON, stated on 08/11/11 at 11:00 A.M. that she was "Not sure who called the police," in relation to the incident between R1 and R2.

R1's and R2's records, provided by E18, Assistant Administrator, on 08/11/11 contain no indications of the police being notified by the facility, as per nurses' notes of the incident between R1 and R2 dated 08/08/11 and 08/09/11.

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Z1, Detective with the local police municipality stated that the facility never called the police to report the incident that occurred between R1 and R2, that only the "Ambulance service called it in."

Police documents dated 08/08/11, indicate in it's Reporting Officer Narrative that R2's clothing worn by R2 on 08/08/11 were "Located in a large gray waste can in the hallway outside (R2's) room...None of the (facility) staff on scene could locate the bottom sheet from (R2's) bed, nor the towels used to clean (R2) after the incident (with R1)."

The facility's Abuse policy indicates on page two, "Prevention, A. Criminal record checks will be obtained per policy." Facility documents titled "Regarding Identified Offendrs Program Requirements" indicate under "The process for the identified offenders program is as follows: 1. When a resident is admitted to a facility, an electronic name-based UCIA (Uniform Conviction Information Act) background check must be ordered within 24 hours."

E3, Business Office Manager, on 08/11/11 at 11:25 A.M., stated that she was the facility staff person responsible for doing criminal background checks, the Illinois Sex Offender Registration checks and the Illinois Department of Corrections sex registrant searches on all new admissions. When R1's criminal background check, Illinois Sex Offender Registration check and Illinois Department of Corrections sex registrant search was requested for record review, E3 stated that they had not been done in a timely manner. E3 stated that when R1 was admitted on 06/02/11 she was off on surgical leave and that Z4, the

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facility's former Administrator, had been responsible for accomplishing these tasks on new admissions. E3 stated that when she returned to work she had checked to ensure that these tasks had been accomplished, "But it hadn't been done (on R1). I did not catch this one," and it was not done until 08/09/11, the day after an alleged sexual assault between R1 towards R2 had been committed.

On 08/23/11 at 1:02 P.M., E3 provided information by type-written letter that E3 had been out of work from 05/29/11 through 06/02/11 due to a surgical procedure. E3 verbally re-confirmed that there had been no other admissions other than R1 in this time span as she verbally stated she had re-checked that particular time span "Many times," since the incident of 08/08/11 between R1 and R2.

E3 provided R1's Illinois Sex Offender Registration checks and the Illinois Department of Corrections sex registrant search done on 08/09/11 and R1 had no indications of being on either of these documents. On 08/16/11 at 9:20 A.M. E3 was re-questioned regarding the absence of a criminal background check being provided for R1. At 10:05 A.M., E3 stated in regards to the company the facility utilized to provide background checks, "I've been checking with them night and day and it's (R1's criminal background check) still pending." E3 added that the company informed her that due to R1 having new, outstanding charges that had not yet been determined "Guilty or not guilty," that R1's criminal background check could not be expected, "Until sometime after September ninth."

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F9999	Continued From page 34 On 08/11/11 at 10:37 A.M., Z1, Detective with the local police municipality, stated that R1 was arrested in 1995 for "Aggravated sexual assault." Z1 stated also that R1 had completed a prison sentence as well as his probation and was no longer required to register as a sex offender. Z1 added that "The only reason we (the police) knew about the previous charge was that it was still in our files because it happened in the same municipality." (A)	F9999		