STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145714	A. BUILDING _____ B. WING _____	C 09/20/2004

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OAK PARK HEALTHCARE CENTER	**625 NORTH HARLEM OAK PARK, IL 60302**

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F9999	FINAL OBSERVATIONS STATE VIOLATIONS ASSOCIATED WITH THIS INVESTIGATION: 300.610 a) 300.1210 a) 300.1210 b) 6) 300.3240 a) 300.3240 f) 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	F9999		

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F9999	Continued From page 13 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 there under. 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. The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. 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. Personal Care, as defined in section 300.330, is assistance with meals, dressing, movement, bathing or other personal needs or maintenance, or general supervision and oversight of the physical and mental well-being of an individual who is incapable of maintaining a private, independent residence or who is incapable of managing his person, whether or not a guardian has been appointed for such individual. (Section 1-120 of the Act). General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision	F9999		

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F9999	Continued From page 14 and assistance to prevent accidents. An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. 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. These regulations are not met as evidenced based on review of facility's abuse policy, staff and resident interview, review of police report and review of the incident report, the facility failed to: (1) Assure that one resident (R1) was free from resident to resident sexual abuse on 08/07/04. (2) Prevent the abuse of R1, who was lying in her bed when R2 came in and sexually abused her. (3) Provide the necessary supervision to one resident, R2, who has a history of becoming intoxicated; will exhibit inappropriate behavior. Facility was aware that R2 continued to drink while residing in facility and failed to supervise him on 8/7/04. Findings include: On the night of 8/7/04, R2 returned to facility drunk and was told to go to his room. R2 was	F9999		

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seen after 7PM going to the smoking room, where he was not supervised, therefore staff did not see R2 leave this area and enter R1's room.

R1 is a 44-year old, mentally retarded female client with additional diagnoses of dehydration, uncontrolled diabetes, seizure disorder, depression and mental impairment. R1 later reported to staff and verified this report when surveyor interviewed her, that she was forced to have sexual intercourse with R2. R1 was sent to hospital for sexual assault on 8/7/04. Police report indicates R1 stated that R2 put his penis " in me." According to the police report, after his arrest R2 admitted that he kissed, fondled, and put his fingers into R1's vagina.

Surveyor interviewed R1 at 11:15AM on 9/13/04. R1 stated that she had her gown on when R2 came into her room, took his clothes off, and "put his thing in her." R1 stated that the hospital checked her for rape and she didn't have any semen noted.

Review of facility's interview with E11 (CNA) revealed that at about 9:15PM R4 came out of her room to ask for assistance with her TED hose . E11 could not respond so E3 (CNA) went in to help R4. E11 stated that when E3 went into the room E3 saw R2 zip up his zipper, leave the room in a hurry and get on the elevator. R4 then told E3 that she witnessed R2 on top of R1. E11 reported the incident to E12 (nurse in charge of 1 main).

E12 began the investigation by calling physician, family, administration, and police on 8/7/04 at approximately 10PM. R1 was immediately sent

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to the emergency room where hospital emergency personnel assessed her. R1 is currently in the facility, continues to be closely monitored by staff, is under the care of an attending physician and is being seen by a psychologist a minimum of twice weekly. Staff reports that she currently appears to be functioning at her baseline and manifests no adverse reactions from the incident.

Nurse's notes reflect that facility staff knew R2 was intoxicated on 8/7/04 and that after R2 returned from his pass they sent him to his room to "sleep it off." R2 then went to bed and slept through the night.

When Administrative staff confronted R2 the next morning, R2 became agitated, refused the disciplinary action proposed by the facility, and signed out AMA (Against Medical Advice). The police later found R2 on 8/9/04 in another facility to which R2 had voluntarily admitted himself. The other facility had requested information on R 2 from Oak Park Healthcare and Oak Park staff notified the police. Police then proceeded to the other facility and arrested R2. As of this survey R 2 remains in police custody.

Z2 (police detective) was interviewed and states that R1 was put to bed at 9:00PM and that the incident occurred and was discovered between 9: 15 and 9:30PM. This interview confirmed Surveyor's observation that R1 could not have pulled her own curtains because in the evening her hands swell and make it difficult for her to pull the curtains herself. R1 has diabetes and loses function towards the evening. Z2 also stated that a rape kit was done at the hospital, but he did not

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have the results back yet. Z2 stated that R2 admitted to the sexual abuse after police interview and admitted to kissing, fondling R1 but stated to police that he only put his fingers in her vagina.

During interview on 09/13/04, E2 (Assistant Administrator) stated that she was paged Saturday evening by E10 (Assistant Director of Nursing) and informed that E 3 had seen R2 in R 1's room and saw R2 zipping up his pants. E2 stated the incident report indicates that R1 reported she was forced to have sexual intercourse with R2. E2 also stated that no one saw R2 go into R1's room "We don't have the staff to do 1:1 at all times; we did do 1:1 on resident after the incident."

E7 (LPN) was interviewed, by phone at 1:15PM on 09/13/04. She stated that R2 had been drinking on 8/7/04 and was under staff supervision. Review of the facility policy defined this as 1:1 supervision. E7 stated she saw R2 before 8:00PM when he went to the smoking room and she was not sure when he left the smoking room. E7 confirmed that they "were to be aware of R2's whereabouts at all times." E7 did not see R2 go into R1's room, but admitted that staff " should be aware of R2's whereabouts at all times" because of his frequent intoxication. E7 told surveyor that E13, a CNA, was to be responsible for the smoking room and supervising the residents there.

Interview with E13 revealed that she was not checking the smoking room as she was on break at that time and she was not aware of the incident until later.

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F9999	Continued From page 18 E2 (Assistant Administrator) stated, during interview on 9/13/04, that no staff on duty saw R2 go into R1's room. E3 (CNA) stated that when she finally went into R1's room around 9:30PM, R 2 passed her in a hurry and went to the elevator; R2 was zipping up his pants. Review of social service notes shows that when R2 is intoxicated he exhibits inappropriate behavior such as kissing, hugging, and touching people and can be verbally abusive. These behaviors are not care planned in R2's medical record. Further review of R2's medical record revealed 11 documented incidents of R2 becoming intoxicated and at times displaying these inappropriate behaviors. Dates for these incidents are: 01/23/04, 01/29/04, 01/30/04, 02/ 24/04, 03/09/04, 03/27/04, 04/06/04, 04/08/04, 05 /27/04, 06/01/04, 07/15/04, 08/05/04, and 08/07/ 04. Social service notes identify that R2 exhibits these behaviors 1 to 3 times (days) per week but only when intoxicated. E14's (social service) notes were reviewed and revealed that she met with R2 on 01/30/04 to talk about his continued drinking and the need to address it. E14 pointed out to R2 some of the behavior problems that seemed to occur when he does drink such as inappropriate touching, hugging, kissing, and verbal abuse. Notes further reveled that R2 had three alleged incidents of drinking in just over a week. On 02/24/04, these notes reflect that E14 had R2 sign a behavioral contract and an alcohol contract. These documents state, "At no time will I harass other residents, staff or visitors. If this	F9999		

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F9999	Continued From page 19 situation occurs, I will be evaluated to be monitored more closely." Social service note of 3/09/04 states that " Resident had just gotten done settling an incident with a staff member, per Asst. Administrator. Resident hugged S.S.D. and shook S.S.D's hand . Resident's breath smelled of alcohol." Social service note of 04/08/04 identifies that R2 "was observed to be intoxicated and smelling strongly of alcohol. Resident was smiling and laughing and touching everyone that came by." R2 was directed to go to his room and lay down. Social service note of 05/20/04 states that R2 exhibited socially inappropriate behavior 1-3 times (days) per week; when intoxicated he will inappropriately kiss and hug people. Notes also state that R2 exhibits verbally abusive behavior 1 to 3 times (days) per week and only when intoxicated. The facility treatment plan for this behavior consisted of making contracts with the resident. These contracts were not effective. In fact, the facility produced 6 previous contracts signed by R2 regarding drug and alcohol abuse. Contracts threaten discharge and encourage alcoholic treatment and groups. Facility sent evidence that R2 attended groups on 4/15/04, 5/17/04, 5/22/04, 5/24/04, 6/7/04, 6/8/04, 6/14/04, 6/16/04, 6/21/04, 7/7/04 and 7/15/04. There was no evidence of resident attending after 7/15/04. The facility was aware of R2's drinking, subsequent need for supervision after returning from pass intoxicated and that the contracts were not effective since R2 was non compliant.	F9999		