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

PAVILLION OF FOREST PARK
Facility Name

0043778
I.D. Number

8200 WEST ROOSEVELT ROAD, FOREST PARK, ILLINOIS 60130
Address

MARCH 2, 2005
Date of Survey

Complaint and Incident Report Investigation
Type of Survey

As a result of a survey conducted by representative(s) of the department, it has been determined the following violations occurred. Please respond to each violation. The response must include specific actions which have been or will be taken to correct each violation. The date 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):

300.1210b)6 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 and assistance to prevent accidents.

300.3240d) 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)

300.3240f) 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 record review, staff and other interview, review of facility abuse policy, and observation, the facility failed to protect one resident (R5) from another resident (R3) with a history of inappropriate sexual behavior even though this behavior was identified initially on May 19, 2004, to protect R5 and others, and failed to have in place any type of care plan or treatment plan to address R3's continued inappropriate sexual activity with R5, who does not have the cognitive ability to make a consensual choice, and on at least one occasion, on

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February 9, 2005, was visibly upset by R3's forceful demands.

Based on the interviews and review of records, it was apparent to the staff that a sexual relationship had been demonstrated between these two residents with one of them not being cognitively or emotionally appropriate for this relationship. R3, who demonstrated sexual activity through masturbation and seeking inappropriate touching and contact with R5, needed to be supervised to protect R5 and others on the unit. The facility treatment plan which called for separation did not preclude the alert and cognitive R3 from ambulating between floors. In fact the facility transferred him back to the second floor not because of need but because of family pressure. The facility took no definite steps to protect the female resident from untoward sexual advances and it appears from the record that he has done this before.

Findings include:

R5 was admitted to the facility on April 3, 2000, with diagnoses including hypertension, CVA with right hemiparesis, dementia, depression and cataracts. Observation of R5 on 2/22/05-2/23/05, on the second floor,, revealed R5 up in a wheelchair but unable to answer any questions from the surveyor. R5's speech was garbled and unintelligible. R5's current MDS (Minimum Data Set) scores the cognitive ability at "2"(moderately impaired, decisions poor, Cues/supervision required).

R3 was admitted to the facility on January 23, 2002 with diagnoses including diabetes, arthritis, COPD and anemia. Observation of R3 on 2/22/05-2/23/05, on the second floor, revealed R3 to be up in a wheelchair and moving around the unit, alert, oriented and able to answer questions from the surveyor. R3 denied that anything had happened or that he had any type of relationship with R5. R3's current MDS scores his cognitive ability at "1" (modified independence, some difficulty in new situations only).

Review of R5's nursing notes for February 9, 2005 at 3:00 p.m. stated the following: "Resident found in 208-2 with male peer. Per resident, I said "no no". Per staff, male peer seen with penis exposed encouraging resident to put head in lap. Resident (R5) removed from R-208-2, Instructed not to return to peer room. Staff will continue to monitor."

Review of R3's nursing notes for February 9, 2005 at 3:00 p.m. completed by E13 (nurse) states the following: "Resident observed by staff with peer, head between leg with slacks open, penis exposed demanding oral sex. Behavior Occurrence Form completed." A further note Completed by E4 (CNA – Certified Nursing Assistant) states the following: "Went to answer call light, noted resident had pants down and exposed his penis to (R5). She was saying "no, no." Took to nurses station." E4 (CNA) stated when interviewed February 22, 2005 that she answered R3's call light on February 9, 2005 and found R3 sitting on the bed with his pants

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down. He had a hold of R5's wheelchair and was saying "you can do it" and R5 was saying "no, no, no". R3's penis was exposed and R3 "kind of jumped back" when E4 entered the room. E4 took R5 out of the room and to the nurse's station. E4 confirmed that this is not the first time this has happened with these residents in the two years she has worked there, and she has "seen them together a lot" talking in the dining room. E4 stated that R5 is not able to consent because she is confused.

E13 (2nd floor nurse) was interviewed on February 22, 2005 and stated that E4 reported to her that she found R3 and R5 together in the room and R5 was saying "no, no." E13 filled out a Behavior Occurrence Report" and reported the incident to the social service department. E3 (ADON) was with her at the time, placed a call to Z3 (attending physician) but he did not call back. R5 was taken to the dining room, talked with her to calm her down, and redirected. She kept the residents separated and R5 went to bed after supper. E13 also stated that once the "Behavior Occurrence Form" is completed, it is given to social service; they handle the rest such as notifying family, etc.

E5 (CNA) was interviewed on February 23, 2005, and stated that she has cared for R5 for three years. R5 is confused and cannot even ask to go to the bathroom. Because she has worked with her all this time, she knows her needs and gestures. E5 used to see R5 and R3 siitting in the hallway together and talking, never saw them together in a room or saw them behave in an affectionate manner. "R3 can talk and he knows what he is doing". E5 stated she has found R3 in his room touching himself (penis) before, but when she would enter the room, R3 would always cover himself. E5 never saw him with any other female residents.

Review of the "Behavior Occurrence Form" made out for R3 dated February 9, 2005 gives minimal information regarding the incident. It states under "Interventions Attempted": redirection, counseled, and stayed with resident. Under "Resident response to Intervention": Behavior continues; and it also states the intervention was "unsuccessful".

Social service notes for R3 for February 9, 2005 written by E10 (social service assistant) stated the following: "SSA met with resident regarding inappropriate sexual behavior toward another resident witnessed by staff. When speaking to resident about this behavior, he denied this behavior. SSA explained to resident that this behavior is inappropriate and shouldn't be presented. SSA will suggest a room change for either resident."

E9 (Social Service Director) on February 23, 2005, stated that she had been informed by nursing that R3 and R5 were together and R3 was trying to perform a sexual act. E10 (Social Service Assistant) had told her of the incident and she then informed the Administrator and

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Director of Nurses. She suggested that they needed to be separated (their rooms were side by side at the time) and called R3's relatives and left a message. Administrator stated to go ahead and move R3 to the third floor. Facility third floor houses ventilator-dependant residents who would be non-mobile and at risk. On February 14, 2005, E9 received a message from R3's relative (also R3's POA) stating that they wanted R3 moved back to the second floor, so the facility moved him back. E9 revealed that after R3 was moved back, she was told by nursing staff that he was pursing R5 again. E9 instituted a tracking log to track his behavior as well as R5's, and had the staff fill out a "Behavior Occurrence Form."

E10 (Social Service Assistant) was interviewed on February 23, 2005, and stated she was told of the incident of February 9, 2005, by the CNA and nurse on the second floor. A "Behavior Occurrence Form" was filled out by the staff and she was notified. She, in turn, notified E9 and E9 placed behavior tracking forms in R3 and R5's charts. It was also suggested that R3 be moved to another floor, but the family did not agree with the move so R3 was brought back down from the third floor. Staff had not reported any other instances of sexual behavior to her and told her these residents had only been observed talking together.

E2 (DON) was interviewed on February 23, 2005, regarding R3 and R5. E2 stated that R3's family did not want him moved to another floor. On February 10, 2005, "R3" was moved to the third floor for several days. R3 had problems with his roommate and asked for a room change. R3 then complained to family that he was being moved again and he wanted to go back to the second floor. R3 was moved back to the second floor on February 16, 2005, even after E2 had spoken to the family and explained why they did not want him back on the second floor. On February 17, 2005, R3 was sent out for a psychiatric evaluation when he refused to be moved back to the third floor. R3 was returned to the facility February 17, 2005, without being evaluated by the hospital because they felt that the resident could be evaluated in the facility. E 2 also stated that R5's family had not been informed about the incident of February 9, 2005.

The facility presented surveyor with behavior tracking sheets for R3's behavior and where-abouts for the dates of February 9, 2005 – February 23, 2005. The only two-hour tracking that was presented are from only February 20, 2005, through February 23, 2005.

Z1 (attending psychiatrist) stated on February 22, 2005, that she was called "right away" when the problem came up with R3. Z1 saw the resident on February 18, 2005, (9 days after the incident), and recommended that the residents be separated. She is currently trying to adjust resident's psychoactive medication (Zoloft) which has the side effect of decreasing sexual urges. Z1 also stated that she had never seen or evaluated R5, but that she probably should to screen her for any secondary sexual side effects.

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The notes written by Z1 on February 18, 2005, do not reflect anything about the sexual incident, and state only that R3 will be monitored. Notes from February 22, 2005, stated that she was notified February 17, 2005, and that R3 was sent for psychiatric evaluation February 18, 2005. resident was returned to the facility and when talked to about his behavior, he denied any sexual misconduct. The plan was to change the resident's room and to increase the Zoloft, and if the behavior continued, it would need to be readdressed with behavior management and transfer out. There is no documentation that Z1 was notified on February 9, 2005 regarding R3's behavior.

Further review of R3 and R5's medical records found care plans for these residents dated from May 19, 2004 regarding inappropriate sexual behavior. These problems are continued through August 10, 2004, November 9, 2004 and January 25, 2004 on these care plans. There was no documentation found by any staff regarding a sexual incident/behavior occurring on May 19, 1994 which would have generated this care plan.

When interviewed on February 23, 2005, E9 stated that the care plan was initiated May 19, 2004 because the nurses had told her that these residents were having sex. E9 did not document any of the information given to her and had no investigation to back up why the care plan had been written. E9 stated that information is given to her from staff, but she does not thoroughly investigate it or write specific documentation of incidents. When asked why the care plan problem had been continued, E9 stated that E10 was actually the one who handled situations on the second floor, and she did not know why the care plan had been continued. E9 had no knowledge of any other sexual incidents occurring with these residents including one documented in the Social Service notes on August 10, 2004.

E10 was interviewed February 23, 2005 regarding the care plans. E10 stated she had no back-ground on R3 and R5's behavior toward each other since being in the facility. Staff had never reported any other instances of sexual behavior between these residents to her. E10 stated that E9 had written the May 19, 2004 care plan.

A Social Service note dated August 10, 2004 for R3 states: "Resident will present with inappropriate behavior that's sexual in nature toward female resident". R5's notes from the same date state: "Resident observed engaging in sexual behavior according to Activities Aide".

When questioned on February 23, 2005 regarding these statements, E10 stated she did not remember what occurred on August 10, 2004, but it was reported to her by E15 (Activity Aide).

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E15 was interviewed February 28, 2005, and stated that on August 10, 2004, around 1:45 p.m., she saw R3 and R5 sitting in the hallway. When she approached them to invite them to activities, R3 had his hand down R5's pants. R3 removed his hand once he saw her. E15 reported the incident to E10 and E13, but does not know what happened after that. E15 denied ever seeing any other sexual incidents between these residents, but did state that she has seen them talking to each other.

Facility's Abuse Prevention and Reporting policy states on page four: #14 – "All instances of resident sexual activity in a non-married or non-committed relationship are to be reported to the charge nurse and administration in order to facilitate evaluation to rule out sexual abuse. The evaluation will include assessment of the cognitive status of both parties, verbal and non-verbal expressions of consent, and safety and health measure for both residents. Responsible parties and the attending physician will be notified to participate in care planning and interventions, if appropriate. If determined to represent a non-consensual activity, the instance will be treated as sexual abuse". #15 – "Facility controls are in place to minimize on-consensual sexual encounters. These controls include ongoing behavioral assessments, care plan interventions and resident visualization approximately every two hours".

The facility did not follow this policy in regard to R3 and R5's relationship prior to the Incident of February 9, 2005.

Facility presented surveyor with a preliminary 24-hour incident investigation report for R5 which stated: "2/10/05 Room 208, resident found in room with male resident, male resident exposed. Above resident is saying "no, no". (Actually date of incident was 2/9/05) A second preliminary 24-hour incident investigation report for R5 that was updated February 18, 2005 states; "unsuccessful attempt of sexual advance, male resident diagnosis alert and oriented; female resident family aware of a consensual platonic relationship, staff successfully interviewed and prevented sexual advance. Investigation and final report to follow".

Interviews were attached with the second report from three staff only – E13 (2nd floor nurse) - Interview dated February 9, 2005, E14 (PM supervisor) interview dated February 23, 2005, and one interview with no name or date. The rest of this investigation only states what is stated in the nurse's notes/social service notes from February 10, 2005, to February 17, 2005. No final investigation of the incident was given to the surveyor, and E2 (DON) stated upon interview of February 23, 2005, that she still had not finished it. E2 also stated that R5's family had not Been notified of the incident.

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Facility's abuse policy states: 21. – "In the event there is resident-to-resident abuse, an investigation will be initiated promptly to determine the most suitable interventions and consideration for relocation of the abuser. The resident's family or legal representative shall be promptly notified of the incident and invited to participate in the care planning/interventions". 23. – The facility Administrator or designee will contact IDPH (Illinois Department of Public Health) by telephone immediately within 24 hours upon determining a situation exists (or existed) that is reportable under the IDPH guidelines for reporting unusual occurrences. 24. – The initial report will contain a brief description of the occurrence, brief description of initiative action initiated and a description of the action taken by the facility to respond to the situation". 25. – The result of the investigation to the IDPH, in writing or by fax, within five (5) working days of the occurrence.

The facility did not follow these policies in regard to the incident between R3 and R5.

Review of the regional office log for incidents on February 28, 2005, revealed that no incident regarding R3 or R5 was received for February 9, 2005. No preliminary report or final investigation report was found.

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