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| F 490 | Continued From page 23<br>Completed 1/19/09.<br><br>12.) All current residents assessed for potential abuse/neglect using Screening Assessment to determine Presentation of Abuse/Neglect Factors. New admits also be assessed using this tool.Completed 1/19/09. | F 490 | | |
| F9999 | FINAL OBSERVATIONS<br><br>LICENSURE VIOLATIONS<br><br>300.615g)<br>300.620d)3)<br>300.1210a)<br>300.3240a)<br><br>Section 300.615 Determination of Need Screening and request for Criminal History Record Information<br><br>g) The facility must review the screenings and all supporting documentation to determine whether the recommended placement of an identified offender is appropriate under Sections 300.620 and 300.625 of the Part. The facility is responsible for the development of a plan of care appropriate to the needs of the identified offender, in accordance with Section 300.625 of this Part.<br><br>Section 300.620 Admission, Retention and Discharge Policies<br><br>d) No person shall be admitted to or kept in the facility:<br>3) Who is an identified offender, unless the requirements of Section 300.615 (f) and (g) for new admissions and the requirements of Section | F9999 | | |

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| F9999 | Continued From page 24<br>300.625 are met.<br><br>Section 300.1210 General Requirement for Nursing and Personal Care<br><br>a) 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.<br><br>300.3240 Abuse and Neglect<br><br>a) An owner, licensee, administrator, employee or agent of a facility shall not neglect a resident. (Section 2-107 of the Act)<br><br>These Requirements are not met as evidenced by:<br><br>Based on record review, staff interview and resident interview, the facility failed to prevent the physical abuse of one resident by another resident for one of the five residents sampled (R2) on 1/17/09 in the early morning hours.<br><br>The lack of assessment and supervision of R3, who informed staff of his sexual preoccupation/frustration prior to the sexual attack, and the lack of supervision and monitoring during early morning hours by staff led to the sexual assault of R2 by R3. R2 was hospitalized with vaginal and rectal tears and was emotionally distraught when admitted. | F9999 | | |

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| F9999 | Continued From page 25<br>Findings include:<br><br>R2 is a 69 year old resident with diagnoses including Schizophrenia and Bipolar Disorder and a history of Catatonia. Interviews of staff caring for R2 were consistent in describing R2 as a good historian with a very good memory, interviewable, but uncooperative with care and at times combative. Staff indicated that she is cordial with staff and other residents, but not sexually provocative or sexually active, and that she never had any previous contact or friendships with R3.<br><br>E7, (night shift nurse for 500 wing), indicated on interview and in a written statement that on 1/17/09, she heard moaning coming out of R2's room and came in to check the resident. E7 found R2 naked in bed, one foot on the floor and the other bent and resting in bed, crying, with a terrified look on her face. E7 indicated that R2 stated someone "made love to her in the front and in the back and he wanted me to tell him that it felt good but it really hurt." E7 indicated that she had written her statement regarding the incident after the resident was sent to the hospital. E7 indicated that her statement was accurate. During interview, E7 indicated that she did not check R2's condition, or physically assess her regarding her complaint of "hurting." E7 indicated that no assessments were done as the police quickly came and then the paramedics came to take the resident to the hospital.<br><br>R2 was interviewed on 1/22/09 at 2:45 PM at the facility she was transferred to after the hospitalization. R2 was escorted into the room by staff and was offered a chair. R2 eased down in a chair with a grimace in her face. Surveyor | F9999 | | |

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| F9999 | Continued From page 26<br>asked her if she was okay. R2 responded that she still had pain when she sits down because of "what happened to her." R2 then proceeded to say that she was "raped" by another resident while in the "old place." R2 identified the facility by name stating she was there for two years or more. R2 indicated that a big black man came into her room, raised her skirt and started to "do it to her." She stated that she started to yell "ow! ow! ow!" a few times to get help, but he put his hand on her face so she could not yell anymore and call out for help. R2 stated that he turned her around and "started doing it behind her." It was not until he was finished that she started moaning in pain. R2 indicated that the nurse that first came into her room was E7 who took her out of the room and by then the police and ambulance came and took her to the hospital. During interview, R2 stated that he hurt her front and back and she did not give permission, or leave her bedroom. R2 stated R3 had never talked to her before. R2 indicated that she has been hurting from her private area and her back since the attack. During the conversation, R2 was shaking and anxious and asked surveyor if she was going to "be in trouble if the guy heard that she was talking about it." R2 stated that she still feels very afraid and denied the sex was consensual.<br><br>Police record reflects that they responded to a 911 call originated by R3 himself indicating there was a rape, and not facility staff, at 1:11 am on 1/17/09. A lead check done routinely indicated that R3 had a valid warrant out of Dupage County. Police report described this current incident as an Aggravated Criminal Sexual Assault. Report indicated R3 freely admitted to assaulting R2. On the report, E7 was asked by | F9999 | | |

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| F9999 | Continued From page 27 | F9999 | | |

the officers what had occurred. E7 responded that it appeared as though (R2) had been "sexually assaulted" by R3. Police then called rescue unit (paramedics) to the scene at 1:25 am. Paramedics came into the scene and documented on their report that R2 was crying and upset and had what looked like drops of blood down the inside of the leg. Paramedics transported R2 to the hospital. Police report also reflects an interview with Z3 (the ER doctor who examined R2). Z3 on report indicated R2 had obvious signs of trauma on her vaginal area. The police report also indicated, "shortly thereafter, the Head Administrator for facility (E1); arrived on the scene, and R/O advised him of what had transpired up until that point." This indicates E1 was made aware of the allegations and situation by the police at the scene.

Z1 and Z2 (paramedics) were interviewed on 1/28/09. Z1 confirmed his narrative wherein he wrote that he was directed to office in the facility where he and his partners found police, facility staff, and patient in the room. Z1 indicated that a female staff was present at that time. Z1 indicated that they observed the patient was upset and crying. Z1 and Z2 both confirmed they observed drops of blood visible on her right leg. Staff was present when this was observed by them. Z1 indicated they were notified that the patient was a possible victim of sexual assault so they were extra careful in handling her. Z1 documented on his statement that he asked R2 if she was in pain and she indicated her "vagina hurt."

Z4, the reporting officer for the police department, was interviewed on 2/3/09 at 9:00 am. Z4 was asked about the content of the narrative

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| F9999 | Continued From page 28<br>regarding what he advised E1 about. Z4 stated that he informed him of what E7 found and what R2 alleged. Z4 stated that he informed the Administrator E1 of the allegation of criminal sexual assault. Z4 stated that E1 was informed that R3 was being arrested for an outstanding warrant and for the allegation of criminal sexual assault. Z4 indicated that he made it clear to E1 that they were treating this as a criminal sexual assault allegation and he was cooperative when we told him that the room is considered a crime scene. The room was closed after the roommate was moved and the facility changed the lock and gave us the key.<br><br>R3's records reflect R3 was admitted to the facility originally on 4/8/08 with admitting diagnosis of Bipolar Disorder with aggression. Stated age is noted as 21 years of age although there is a discrepancy in birth dates and he appears older. Psychiatric evaluation indicated he has a history of agitation and aggressive behavior. PRSC notes indicate he was admitted to the facility for structure and supervision. On 5/1/08, the PRSC indicated that R3 was taken into custody by police from this facility, sentenced that afternoon, and would be taken to Cook County. There is no evidence the facility followed up with this knowledge at the time or later when they readmitted this resident. No other documentation was noted on why the resident was removed by the police and what charges caused the police to take the resident from the nursing home. On 11/10/08, R3 was readmitted from another nursing home. There was no indication that facility staff involved in the admission attempted to assess or clarify the charges that caused the arrest previously at the nursing home to determine impact on care for R3 | F9999 | | |

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| F9999 | Continued From page 29 | F9999 | | |

and other residents. E3, the admission coordinator, stated she did not know he was arrested before and showed a document stating he was cleared by nursing and psychosocial for admission. E4, the PRSC who documented the previous arrest, indicated she did not know why he was arrested. E2 (assistant administrator/head of psychosocial programs) indicated on interview that he had received a phone call from R3 at the other nursing home stating he wanted to come back . E2 did not know what he was arrested for either.

R3's previous nursing home was contacted. Z5 (the social service director and PRSC for the home) indicated that R3 was in his office making the phone call in front of him requesting admission to Maplewood. Z5 indicated that he was given the phone and Maplewood social service told him that they were accepting R3 back. Z5 offered to provide admission information but they indicated that they already knew R3 as he was a previous resident. Z5 indicated that R3 had a history of behavior problems in his building including pulling fire alarms in order to go out to use drugs. Z5 also reported their background check revealed R3 had multiple convictions that included aggravated battery with a weapon, Domestic Battery, and Fleeing from police. Z5 was asked if this information was shared with Maplewood before transfer. Z5 indicated that he had offered to provide the information but staff told him that they were aware of R3's history. There is no evidence that these maladaptive behaviors were evaluated as part of the resident's assessment and treatment plan upon readmission.

Review of the facility background check that was

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| F9999 | Continued From page 30<br>submitted on 11/22/08 reflects the facility submitted R3's name but used the wrong birthdate thus not getting the same result as the previous facility. The facility did not follow up on the previous arrest that occurred while the resident was in the facility that resulted in imprisonment that they had knowledge of. R3 had a domestic battery conviction that resulted in a jail term. R3 was also in prison for aggravated battery/weapon. The facility failed to screen R3 properly and provide a safe environment for the other residents.<br><br>Review of PRSC notes dated 12/5/08 state "Resident verbalized feelings of increased sexual urges and thoughts since the separation of resident and his fiancé due to resident re-admission to facility." PRSC and resident reviewed options such as the use of materials like magazines, and videos, as well as masturbation. R3 was then referred to E2, assistant administrator and the director of psychosocial department. E2 documented on 12/5/08 "Resident referred by PRSC for further conversation regarding feelings of loss related to relocating from his fiancé and sexuality concerns. Resident related that he feels more comfortable talking to PRSD as another male. Resident related to several staff that he was used to having sexual intercourse with his fiancé almost daily at his former home. He related that he wants to be faithful to her but still gets horny. PRSD normalized resident's feelings due to resident being a young man close to his sexual peak. Encouraged resident to stick with his resolution to be faithful, but discussed options for self relief. Resident related that he does not masturbate as an option. Discussed with resident using magazine and video. Resident | F9999 | | |

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| F9999 | Continued From page 31<br>related that he does this." There was no additional monitoring as an update or action taken by staff after R3 expressed this initial sexual frustration.<br><br>The facility keeps a CNA rounds sheet where staff document residents' condition during their every 2 hour rounds during the night. R3 was already documented as "U" (up somewhere on the floor) at 12 midnight on 1/16/09 for the 2300 wing round sheet. The facility has no process for locating or monitoring residents that are unaccounted for during rounds, when residents are to be in bed. The 500 wing CNA rounds documented R2 as sleeping at 10 pm, and 12 midnight, and to hospital at 2 am. R3 who resided on 1st floor had to make his way in early AM hours past nursing station to R2's room.<br><br>E7, nurse who came in immediately after the incident, indicated she never asked R2 if she was assaulted because she wanted to keep her safety as priority. E7 indicated that R2 was crying and looked terrified while stating "he made love to me in the front and in the back." E7 indicated she did not examine R2 or question her because she did not have the time. E7 indicated she was later called to E1's office on 1/19/09. E7 stated that E1 was there with a lawyer. E7 stated she was asked about what she wrote on her statement. E7 indicated that she was not asked by the administrator whether it was her observation/assessment that the sex was consensual or forced based on her initial nursing evaluation.<br><br>E10, 2nd floor nurse for the 1/17/09 incident, was present. E10 on interview also indicated that R2 was crying and complaining of pain when he saw | F9999 | | |

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| F9999 | Continued From page 32<br>her in the front office with the police and E7. E10 indicated that he did not ask her any questions or examine her as the police were already there questioning R2 and E7. E10 indicated he did not write any statement. E10 was asked about the statement typewritten with heading "interview with (E10)." E10 indicated the statement was from the interview held by E1 and the lawyer.<br><br>E9, CNA witness to some part of the incident, indicated on interview that while escorting R3 out of the room, R2 started crying again stating "he made love to me in front and in the back." E9 indicated that R2 looked very afraid, holding E7's hands and crying. E9 indicated that Administration staff did not ask him about the incident.<br><br>E8, CNA witness to some parts of the incident, also indicated that R2 was crying when she saw her outside the room by the door. E8 indicated that Administration staff did not ask him about the incident that night.<br><br>Final result of facility investigation came to conclusion that sex was consensual.<br><br>Review of emergency room records reflect Z3, the emergency room doctor, documenting on his impression /diagnosis as Alleged Sexual Assault, right labial abrasion and perirectal tear. Discharge diagnoses include; Status post sexual assault. Hospital documentation of her psychosocial/ mood description as anxious, fearful and guarded with precipitating stress factors due to pain, situational crisis and traumatic injury. Resident also admitted to status post sexual assault. R2 complained of pain on the vaginal area. | F9999 | | |

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| F9999 | Continued From page 33<br><br>The facility initially notified IDPH on 1/17/09 reporting the incident, with R2 quoted as stating, "Someone was making love to me" and staff finding R3 in the bathroom calling 911 stating, "Someone was attacking the resident." R2 was sent to the hospital and police took R3 into custody. Two days later, the facility sent a "final report" on 1/19/09 with a conclusion" it appears the sexual intercourse between these two psych residents was consensual. Female resident (R2) never alleged abuse in her discussion with staff immediately or later when calling for the police. The report was written by E1.<br><br>E1 indicated that he did not have a chance to talk to both parties involved (R2 and R3) as they were already gone when he showed up. There was no further investigation done. There was no follow through with police on R3 who was arrested or R2 who was sent to the hospital. The facility did not check to see if any other residents were victimized or review the policy that failed. The facility submitted a report to IDPH with minimal investigation and then provided a conclusion to state that the incident was a consensual sexual intercourse without consideration of R2's emotional distress and physical condition.<br><br>(A) | F9999 | | |