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

COUNTRYVIEW TERRACE	0046078
Facility Name	I.D. Number
52 OLD ROUTE 45, PO BOX 116, LOUISVILLE, ILLINOIS 62858	
Address, City, State, Zip	
27639, 18196	SEPTEMBER 29, 2009
Reviewed By	Date of Survey
ANNUAL AND COMPLAINTS 0953153, 0953880	10070, 14206
Type of Survey	Surveyed By

As a result of a survey conducted by representative(s) of the department, it has been determined the following violations occurred.

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):

350.620a)
350.1210
350.1230d)1)2)
350.3240a)
350.3750

Section 350.620 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually.

Section 350.1210 Health Services

The facility shall provide all services necessary to maintain each resident in good physical health.

Section 350.1230 Nursing Services

d) Direct care personnel shall be trained in, but are not limited to, the following:

1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention.

2) Basic skills required to meet the health needs and problems of the residents.

Section 350.3240 Abuse and Neglect

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

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Section 350.3750 Consultation Services and Nursing Services

Residents needing nursing care shall be admitted to an ICF/DD of 16 Beds or Less only if the facility has adequate professional nursing services to meet the resident's needs. Arrangements shall be made through formal contract for the services of a licensed nurse to visit as required. A responsible staff member shall be on duty at all times who is immediately accessible, and to whom residents can report injuries, symptoms of illness, and emergencies (see Section 350.810(a)). The consultant nurse shall provide consultation on the health aspects of the individual plan of care and shall be in the facility not less than two hours per month.

These Regulations were not met as evidenced by:

Based on observation, interview, and record review the facility's nursing consultant failed to prevent neglect for 1 individual (R2) who resided at the facility until 6/08/09, and for 1 of 4 individuals (R5) who currently resides at this facility. R2 fell 15 times from 1/05/09 thru 5/20/09. R5 fell 12 times from 1/02/09 thru 7/21/09, resulting in a fracture on 7/21/09.

The nurse failed:

1) to implement the facility's abuse and neglect policy;

2) to monitor all falls for trends and patterns;

3) to monitor and review falls/incidents in a timely manner;

4) to develop and implement fall prevention programs;

5) to develop and implement corrective action to prevent further falls and injuries;

6) to monitor individuals appropriately after falls;

7) and to train all staff in fall prevention and safety.

Findings include:

The facility's Abuse Prevention Program, dated 3/05/09, states "the purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, neglect, or abuse of our residents." This policy defines neglect as "the failure to provide goods and services necessary to avoid physical harm, mental anguish, mental illness, and such failure results in the deterioration of a resident's physical or mental condition."

This Abuse Prevention Program states "At least quarterly, the Quality Assurance Committee will review concern identification reports, accident reports, incidents reports....and safety committee

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reports to assess possible patterns or trends of suspicious bruising of residents, unexplained accidents, and injuries of unknown origin or other occurrences that may constitute abuse, neglect, or theft. Based on an assessment of the reports, the Quality Assurance Committee will further investigate and/or determine whether a change in facility practices is warranted.

The Abuse Prevention Plan states "The nursing staff is additionally responsible for assessing the resident, reviewing the documentation and reporting to the administrator or designee."

1) Review of the physician's orders dated 8/1/09 - 8/31/09 shows R5 is a 50 year old female with diagnoses of Profound Mental Retardation, Scoliosis, and Autistic Behavior. According to a Psychological Consultation Report dated 4/09/09, "(R5's) cognitive abilities were last assessed on 10-29-05, using the Slosson Intelligence Test." The results reflected an Intelligence Quotient was determined to be 10. This report also states that the Inventory for Client and Agency Planning was completed on 4/9/09 with a Broad Independence score of 0-7 months.

According to an incident report dated 7/21/09, R5 fell at the facility on this date at 9:18 P.M. fracturing her upper right arm and sustaining a possible concussion. This report states, "Fall in walker wheel on (name of an adult walker) turned outward causing (R5) to fall sideways on floor while in (the adult walker). Staff assisted (R5) up from floor noticing arm obviously broken and large bump on (R) side of head - immediately called 911." This report states she was transferred at 9:23 P.M. on 7/21/09 by ambulance to local emergency room. The report states she was later transferred to another hospital and was seen by an orthopedic surgeon.

Review of the hospital's discharge summary, R5 was transferred to another hospital "due to question of intracranial bleed." CT scan of R5's right arm shows "displaced midshaft Fx (fracture) of humerus. CT scan of head confirmed a "right front parietal hemorrhagic contusion and evolving right scalp hematoma."

According to the discharging hospital's Facility Transfer Report dated 7/22/09, the physician stated R5 "will be fitted with a humeral fracture brace and symptomatic and supportive care is recommended along with follow up in the Orthopedic Fracture Clinic..."

According to the facility's Observation Notes dated 7/23/09, "(R5) arrived home at 12:15 A.M."

Review of additional observations as recorded by direct care staff shows the following:

7/23 - 6-2 shift; "(R5) home today. Balance is very unsteady. During one on one walking (R5) did go backward 2 times. Staff worried about putting in (adult walker) due to possibly re-injuring arm when she would fall backward. Sat her in wheelchair...She refused to use a pillow to prop arm in air...Put (R5) in (adult walker) at 9:45 A.M... While staff was cleaning the walker, (R5) twisted her self and fell backwards. Staff controlled the final descent. She did not hit the floor. But if left alone she would have been reinjured....returned to the wheel chair...Fingers are purple and edema is present on hand of broken arm."

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7/23 - 11-10 P.M. shift; "(R5) had returned from (name of hospital) last night with splint and sling. No information was given to staff other than keep it dry and elevated, returning if any problems presented. (R5) continually moved arm from sling and pushed on the chair with it." The notes continue to document that E2/Direct Support Person (DSP) called the emergency room (ER) and then the ER contacted the orthopedic surgeon that applied the brace and sling to R5's arm for instructions.

7/24/09 - 11A - 9A; R5 "was up all night. She showed signs of hurting, she was yelling, which is not normal. She was crying (had tears coming from eyes). Showing pains a few times as well as through the night."

7/27/09 - time unknown; R5's "arm is swelling more then earlier."

In an interview with E1, Administrator, on 7/28/09 at 2:00 P.M., E1 said R5 was taken back to the emergency room because her right hand and arm were very swollen. The doctor told staff this was normal since R5 won't keep her arm elevated. E1 said she was not aware of any instructions of how to monitor R5 for edema, but then E1 said the facility's nurse may have, and instructed surveyor to check the nurse's notes.

Per review of the nurse's notes dated 7/24/09, the nurse assessed R5 noting the brace was intact to her right upper arm with "edema noted to (R) hand." Nurse also documented the hematoma to R5's right scalp had a small amount of bruising....."staff to continue monitoring." No specific instructions were made as to what the staff should monitor.

On 7/29/09 R5 was seen by Z4 (Physician Assistant) and orders written to: "1) elevate hand above heart 2) if pt can't move fingers, (symbol for decreased) radial pulse, fever, (symbol for increased) pain, needs appt with me or (name of Orthopedic Surgeon)."

Surveyor observed R5 at the facility on 7/27/09 and 7/28/09 in the adult walker throughout the day. R5's right arm below her elbow and her right hand were extremely edematous.

E3/DSP was interviewed on 7/28/09 at 12:48 P.M. E3 said R5's arm and hand were very swollen and she tried to massage her fingers to help reduce the edema. E3 said R5 won't hold her arm across her chest and lets it dangle in her lap.

E12, RN (Registered Nurse) consultant's only documentation in R5's nursing notes after R5's fall of 7/21/09 and ensuing fracture is dated 7/24/09, "Res assessed. Brace intact to (symbol for right) upper arm - edema noted to (symbol for right) hand - nail beds pink, blanch 3-5 sec, pulse regular - hematoma can’t to (symbol for right) scalp - sm to mod amt of bruising noted to hematoma - neuro checks WNL - staff to cont monitoring."

There is no documentation in R5's record that the facility staff notified E12 of R5's readmission to the facility, nor is there any documentation the staff notified E12 regarding R5's continued

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problems with ambulation. The nurse did not instruct the staff regarding the care of R5's fractured arm, nor did the nurse give the staff any instructions in maintaining R5's right arm in proper alignment to promote healing.

There is no documentation in R5's record by E12 regarding R5's fall on 7/21/09, her hospitalization of 7/21/09 to 7/22/09, any instructions regarding the care and positioning of R5's fractured arm, or any recommendation to have R5 assessed by a Registered Physical Therapist after her injury and continued unsteady balance. Per review of R5's record, the last evaluation was conducted by a Registered Physical Therapist was dated 8/04/08.

R5 was observed at the facility on 8/03/09 at 4:45 P.M. She was sitting in a small wheelchair in the facility's dining room. She was wearing a sling on her right arm, and had a brace from her right elbow to her shoulder. R5 was propelling the wheelchair mostly in a backwards direction and shoving it into the tables, chairs, and into another client, R11.

At this time, R11 was sitting in a wheelchair in the facility's dining room. When R5 ran into R11's legs with her wheelchair, R11 said, "Ouch." There were no staff in the room and another client, R16, pushed R5 in her wheelchair to another part of the dining room. Within a minute R5 had propelled herself back to the dining room area, and continued to run into the tables and chairs. R16 would attempt to move her away from him and the furniture.

During this observation, R5 continuously rocked her upper body forward and then backwards. When she came backwards her right upper back and right shoulder would hit the back of the wheelchair, moving her right arm within the brace. Her arm was in a sling, but it was not elevated and was wedged under the wooden arm rest of the wheelchair.

R5 was observed on 8/04/09 at 7:30 A.M. sitting in the wheelchair in the facility's dining room. She again was rolling the chair about with her feet and bumping into furniture and other clients.

On 8/05/09 at 2:30 P.M., E2/DSP reported to surveyor that R5 had an open area on her upper right arm underneath the brace. At this time, the surveyor observed this area with E12 present. It was approximately the size of a fifty cent piece, red in color, with the top layer of the skin gone. The area is on R5's upper right arm, underneath the brace, and towards the outside of her arm.

The Observation Notes dated from 8/01/09 through 8/10/09 were reviewed in R5's record, and no documentation was found regarding the open area on R5's arm. R5's Nursing Notes were reviewed and no documentation was found that the facility's staff had notified the facility's R.N., E12, of R5's open area located on her upper right arm. No documentation was found regarding the open area or any monitoring of it by the nurse.

The Observation Notes in R5's record document the following information regarding her fractured right arm:

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8/10/09 at 3 - 11 P.M. states, "(R5) had surgery on her arm today and is staying overnight at (local hospital)."

8/11/09 2 - 10 P.M. document, "(R5) returned home at 7:15 from the hospital."

8/12/09 11 - 9 A.M., (R5) sleeping in social area. Slept until 2 A.M. Giving pain med per Doctor's order. ...pain med at 6 A.M...Walked to bathroom at 9 am seemed to be in a lot of pain..."

8/12/09 2 - 10 P.M., (R5) was transferred to a (local nursing home) to receive 24 hour nursing care after her surgery." The notes document she was readmitted to this facility on 8/14/09.

A further example of the facility's failure to prevent neglect is evidenced by direct care staff's documentation of R5's changes of condition during the month of April, 2009. DSPs noted the following:

4/18/09 - 2P - 11P shift; R5's "left hand was swollen up this evening". Staff called the nurse who advised them to "keep an eye on it and give at (name of non-prescription pain medication) as needed".

4/19/09 - 7A - R5's; "left hand swelled. She acts like it hurts with light touch."

4/20/09 - 11P - 9A; Left hand "is swollen. Warm to touch. Pulls away with light touch."

4/20/09 - 3P - 11P; "Hand is still slightly swollen."

4/26/09 - 3P - 11P; Staff noted R5 "seemed to lose her strength in her left hand and would drop the cup."

4/28/09 - 2-11; "She did fall after supper."

4/30/09 - 6A - 2P; "The (L) hand still has slight swelling. Refuses to hold anything in it this A.M."

On 4/25/09 an Incident/Accident Report documented R5 also fell on 4/25/09 at 12:15 P.M. in the facility dining room hitting her head on the floor.

There is no documentation that the facility nurse was called about the swelling in R5's left hand after the first notification on 4/18/09, nor was any documentation done by the nurse regarding R5's left hand. The only nursing documentation found in April was dated 4/3/09 and 4/5/09. The next Nursing Notes were documented on 5/09 stating, "Ears irrig - Tol well."

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The nurse's quarterly report completed by E11, RN, on 5/31/09, does not document any information or follow up to R5's hand. In this Nursing Health Review & Physical Assessment report she checked "No Problems Noted" under the section for "Hands."

This nurses quarterly report does not specifically address the falls R5 had on 4/25/09 and 4/28/09. The report states R5, "hit head during fall." No further information was documented.

On 8/12/09 at 1:00 P.M. per telephone, an interview was conducted with E11. She said the facility staff contacted her on 4/18/09 by telephone. E11 she said she told the staff "to keep an eye on it," and then said, "I probably told them to call the doctor if it got any worse." E11 said she might have seen R5's hand, and she would have documented if she saw it. The surveyor told E11 that no documentation was found regarding her checking R5's hand. Then E11 said, "Well, if I was met at the door by others I probably forgot to document about (R5's) hand."

The facility's incident reports and Observation Notes dated 1/02/09 to 7/21/09 document the following information about R5:

1/02/09 - 8:45 P.M.; "Slipped on floor, hit head on office door on right side of head." - No documentation that E11 was notified of fall and injury. E11 signed the incident report on 1/23/09 as the date she reviewed it. No documentation by E11 in the nursing notes regarding the fall.

1/24/09 - 8:50 P.M.; "fall - unknown - seemed to be walking funny this evening" Follow up assessment gave more information stating "she fell backwards and hit her head on the door facing."- No documentation E11 was notified. There was no documentation by E11 regarding the fall, and she did not review the incident until 4/05/09.

1/31/09 - 6 P.M.; "(R5) took 2 or 3 steps back and fell backwards hitting her head on the door and then on the floor. She has a lg bump on the back of her head. Staff applied ice pack, did neuro asses and called nurse" E11 was called by the staff, but there is no documentation of any follow up by the nurse. This incident was not reviewed by E11 until 4/5/09.

3/20/09 - no incident report found - information found on an Emergency Room instruction sheet; "Went to ER head injury - fell at Day Training" Additionally, no follow up assessment or neurological assessment found to be completed by facility for this fall. No documentation of E11 being notified about the fall and of the ER visit.

3/21/09 - 7 A.M.; "(R5) was being helped by another resident due to another resident in the way. (R5) lost her balance and fell hitting her head" The nurse was called, but no documentation of any further follow up by the nurse.

4/25/09 - 12:15 P.M.; "was walking in the dining room when she lost her balance and fell...hit her head on the floor" - E11 not notified of the fall and did not review the incident report until 5/31/09.

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4/28/09 - 6:30 P.M.; "standing in dining room no one close to her. She fell over landing on butt and elbows". The Follow - up Assessment report dated 4/29/09 states "Also have two areas on left knee. Open areas 1 a quarter size and one dime size." Again the nurse was not notified of the fall and injuries. The nurse did not review the report until 5/31/09.

5/1/09 - 6:45 P.M.; R5 "fell tonight" and "has a bump on the (R) side of her head". Staff took R5 to the Emergency Room and were told to watch R5 for "nasal or ear discharge, vomiting, unsteady gate (gait)". The facility nurse was not notified of fall, injury, and of the visit to the ER. The only nursing notes documented after the fall of 5/01/09 was on 5/5/09 and states "Ears irrig. Tol well."

5/2/09 - 11p - 9A shift; Staff noted "swelling in (L) hand & bruising to upper (L) arm. The nurse was not notified of this change in condition.

5/2/09 - 3P - 11P shift; R5 "fell again tonight. She has no new injuries at this time." Again, the nurse was not notified.

5/3/09 - 11P - 9A shift; "has more bruising by (L) elbow. Hand (L) is swelled. Knuckles are red & warm to touch." E11 not notified of this change in condition.

5/3/09 - 7A - 3P shift; R5 "fell again after lunch. She hit her head and has a bump." Was placed in a adult walker to "prevent further incidents." Again nurse not notified.

5/11/09 - 3P - 11P shift; R5 still using adult walker. Staff noticed R5's left hand was bruised and swollen. Doesn't "want anyone to touch it." Nurse not notified of this change in condition.

5/13/09 - 11P - 9A shift; R5 "seems to be favoring her left hand." Nurse not notified.

5/15/09 - Went to doctor because night staff noticed R5's veins on her left lower leg are bulging. While in the doctor's office, R5 "fell, landed on buttocks and Rt elbow. The back of her head hit the door of the cabinet." Doctor examined R5 and noted no injuries. The doctor said the bulging veins and bruising were from her previous falls.

The observation notes do not document the resolution of the bruising and swelling in her left hand and elbow. The Nursing Notes were reviewed for the time frame of 1/23/09 to 7/24/09 and there is no documentation of any assessment by the nurse regarding R5's continued falls.

7/21/09 - fell while using adult walker - to Emergency Room - fractured right arm

7/24/09 - 11A - 9A; R5 "was up all night. She showed signs of hurting, she was yelling, which is not normal. She was crying (had tears coming from eyes). Showing pain a few times as well through the night".

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7/27/09 - time unknown; R5's "arm is swelling more then earlier."

E3 was interviewed on 7/29/09 at 12:48 P.M. and said R5's fall on 7/21/09 was due to a broken wheel on the adult walker. Since R5 returned from the hospital, staff initially put her in a wheelchair, using a gait belt to transfer her. E3 stated R5 is now in a new, smaller adult walker. E3 said she was not aware of any instructions to monitor R5 for edema.

Per review of R5's falls from 1/02/09 thru 7/21/09, R5 fell 12 times, requiring three examinations in the local hospital's Emergency Room, and the third time she required a transfer to a larger hospital further away from the facility. She remained at this hospital under the care of an orthopedic surgeon from 7/21/09 to 7/22/09 due to a fracture of her right arm. Then on 8/10/09, R5 required readmission to the hospital for surgery, as it was determined to not be healing correctly when her arm was X-rayed on 8/06/09.

R5's records, including incidents/accident reports and nursing notes from 1/09 thru 7/21/09, and R5's Individual Service Plan dated 4/09/09 were reviewed. There was no documentation of the facility's nurse monitoring R5's falls for trends and patterns and no documentation the nurse implemented any corrective action measures to assist in preventing R5 from falling. R5 was not assessed for risk of falls. Nor did the nurse develop and implement any fall prevention plan for R5. The nurse did not train the staff in fall prevention measures prior to R5 receiving a fracture, nor after the fracture.

The nurse failed to monitor changes in R5's condition. She did not recommend a Physical Therapy assessment for R5 when she continued to have falls. She did not ensure the adaptive mobility equipment R5 used was correctly fitting and appropriate.

R5's last evaluation by a Registered Physical Therapist was dated 8/04/09 and this evaluation states "Has (name of adult walker) - doesn't ever use. (Had couple accidents); amb. (symbol for independent)...Res up ad lib in facility...scoliosis impacts gait pattern, safety, balance."

The facility did not implement their own Abuse Prevention Policy by failing to conduct any safety committee meetings or Quality Assurance Meetings, as they are named in the facility's Abuse Prevention Policy, to prevent neglect.

E1 told the surveyor on 8/05/09 at 3:30 P.M., "We haven't been looking at patterns and trends of falls." She continued saying that E8/Social Service Designee and the nurse review the falls. She said she had not held any special Interdisciplinary Team meetings regarding R5's falls and that a fall prevention plan had not been written for R5.

When the surveyor asked E8 about R5 falls, she named E1 and herself as the ones reviewing falls. According to E8 on 8/05/09 at 2:30 P.M., she said, "(E1) and I go over the falls every month."

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Then on 8/12/09 at approximately 1:00 P.M., a telephone interview was conducted with E11. E11 said she quit being the facility's consulting nurse on 5/30/09. She said there was not a safety committee to review falls. E11 said she would review incidents when she was at the facility and that the date and signature at the bottom of the incident reports indicated when she reviewed them.

E11 said she never looked at patterns and trends for falls saying, "I never saw them all together." She said she did not realize R5 had fallen 12 times since 1/02/09. She confirmed she did not develop a fall prevention plan for R5.

During this same interview, E11 said she had not conducted any in-service training for the staff in preventing falls. She said, "I know to do this at the nursing home, but just didn't think to do so at (name this facility.)"

An interview was conducted by telephone on 8/12/09 at 1:40 P.M. with the facility's current nurse consultant, E12. She said she started at the facility on 7/01/09. E12 confirmed she had not developed a fall prevention program for R5 or trained the staff in fall prevention since starting at the facility.

Per review of R5's Nursing Health Review & Physical Assessment completed by E11 on 3/31/09, the nurse had placed a check by "unsteady gait." The nurse documented by the Comment/Recommendations, "Res amb, unsteady gait." Per review of R5's Incident Reports from 1/02/09 thru 3/31/09, she had fallen 5 times during this time frame. She had been taken to the local hospital's emergency room on 3/20/09 due to a fall and hitting her head.

The next Nursing Health Review & Physical Assessment was dated 5/31/09. E11 placed a check mark by "unsteady gait" and by "Hx of head injury." She wrote, "Hit head during fall." From 3/31/09 thru 5/31/09, incident reports document R5 fell 6 more times, requiring a visit to the ER again on 5/01/09 due to falling and hitting her head. Also an incident report dated 5/03/09 documents R5 fell at the facility, hitting her head and receiving a large lump to back of her head. Under Comment/Recommendations on the 5/31/09 assessment, the nurse documented "amb with "(name of adult walker)" device. No s/s acute distress."

2.) According to the facility's undated roster, R2 functions in a Mild Level of Mental Retardation. The physician orders dated 5/09 indicate R2 also has a diagnosis of Dementia and he is 65 years of age.

Per review of the facility's Incident Reports, R2 fell 15 times from 1/05/09 thru 5/20/09. According to the facility's roster R2 was discharged to another facility on 6/08/09.

On 8/12/09 at approximately 1:00 P.M., a telephone interview was conducted with the facility's prior consulting registered nurse, E11. E11 said she quit being the facility's consulting nurse on 5/30/09. She said there was not a safety committee to review falls.

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She said she never looked at patterns and trends for falls saying, "I never saw them all together." She said she did not realize R2 had fallen 15 times. She confirmed she did not develop a fall prevention plan for R2.

An interview was conducted with Z4/ Physician Assistant on 8/10/09 at 2:50 P.M. per telephone. She said she did not realize R5 had fallen 12 times since 1/09 and that R2 had fallen 15 times from 1/09 until his discharge in June. She said, "I'd have to agree that the facility was not aggressive with their fall prevention for (R5) and (R2). I should have been contacted every time (R5) and (R2) fell." She also said the facility should have developed and implemented an "aggressive fall prevention plan for them."

(A)

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As a result of a survey conducted by representative(s) of the department, it has been determined the following violations occurred.

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"A" VIOLATION(S):

350.620a)
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Section 350.620 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually.

Section 350.625 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. 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 350.1060 Training and Habilitation Services

e) An appropriate, effective and individualized program that manages residents' behaviors

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shall be developed and implemented for residents with aggressive or self-abusive behavior. Adequate, properly trained and supervised staff shall be available to administer these programs.

Section 350.3240 Abuse and Neglect

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

b) *A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator.* (Section 3-610 of the Act)

c) *A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative.* (Section 3-610 of the Act)

d) *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)

f) *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)

These Regulations were not met as evidenced by:

Based on observation, interview and record review, the facility failed to protect individuals from physical, mental, and emotional abuse affecting all individuals currently residing in the facility (R1, R3 - R17) and 1 individual (R2) who resided at the facility until 6/8/09 as evidenced by the facility's failure to:

1) Report all incidents of peer to peer aggression, sexual abuse and injuries immediately to the administrator and to the Illinois Department of Public Health;

2) Promptly notify guardians of any allegation of abuse;

3) Investigate all allegations of sexual abuse and all incidents of peer to peer aggression and to assess for trends and patterns of such occurrences;

4) Ensure sufficient staff are on duty and available to protect all individuals in the facility;
5) Take corrective action to prevent further sexual abuse and/or injury; and

CONT.

6) Provide training in sexuality education.

Findings include:

1) According to physician's orders dated 6/1/09 - 6/30/09, R1 is a 74 year old male with diagnoses of Hypertension, Parkinson's Disease and Psychosis with dementia.

Review of R1's psychological report dated 10/21/08 shows R1 has an IQ of 22 which "places him in the bottom portion of the Severe Range of Mental Retardation." The Inventory for Client and Agency Planning (ICAP) dated 10/6/08 assesses R1 at an overall functioning level of 2 years, 6 months.

The behavior notes found in R1's chart reflect the following information:

1/25/09 - 7A - 3P shift; Staff heard R1 yell from the bathroom. "Staff looked through open doorway and saw another resident (R2) with his hand down (R1's) pants." Staff "called the administrator and informed her of the situation. Staff did random checks on (R1) throughout day."

3/8/09 - 3P - 11P; Staff heard R1 yelling from the bathroom and went to check on R1. Staff saw R1 "running from the bathroom with his slacks in his hands." When staff initially questioned R1 what happened, he pointed "to the bathroom saying another client's name (R2)." A third individual (R6) was "standing in the doorway. He stated another client had been sexually inappropriate with (R1). Staff asked R1 'Did someone do something to you and again he replied with the client's name (R2)." Staff also noted R1 would not leave staff's side and "wouldn't go to his room to bed."

5/9/09 - 10:25 P.M.; R1 "was heard yelling from bathroom. Staff checked on him and another resident (R2) had been messing with him".

5/11/09 - 3P - 11P; R1 "stayed in hallway most of night. He watched staff this evening."

5/15/09 - 7P; Staff charted that R1 kept trying to pull staff where R1 wanted them to stand. R1 yelled when staff tried to stand in another area. "Staff then noticed another resident (R2) was on the couch doing something inappropriate. Once this inappropriate action was stopped, (R1) was fine."

E6, Direct Support Person (DSP), was interviewed on 8/4/09 at 2:15 P.M. referencing the incident of 5/15/09; E6 said she had never seen R1 so afraid before. E6 said R2 unzipped his pants and exposed himself while sitting on the couch and when R1 noticed this, R1 got very upset, and would not calm down until other staff stopped R2 from his behavior.

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Per review of the Maximum Growth Potential Plan dated 10/21/08, R1 "is a victim of sexual abuse. (R1) is unaware of relationships and how they relate to him. He does not pursue sexual actions toward himself or others. Though, he may be a victim if a male tried to do sexual actions to him."

Surveyor interviewed E2 (DSP) on 7/27/09 at 3:00 P.M., E5 (DSP) on 8/3/09 at 4:50 P.M. and E6 (DSP) on 8/4/09 at 2:15 P.M. E2, E5, and E6 said staff really tried to keep an eye on R1 and R2 before the incident of 5/9/09 but did not always see when R1 or R2 would go into the bathroom.

During a telephone interview with R1's guardian (Z5) on 8/11/09 at 4:37 P.M., Z5 said she was contacted about the incident of 5/9/09 but not about any prior incidents. Z5 said she was not aware of any prior issues of possible sexual abuse towards R1.

There is no evidence that the 1/25/09 and 3/8/09 incidents were reported to the Illinois Department of Public Health or that the 3/8/09 incident was immediately reported to the administration or designee.

E1, Administrator, was interviewed on 7/27/09 at 10:15 A.M. E1 confirmed that she only reported the 5/9/09 incident to the Illinois Department of Public Health. E1 said staff only "call her about the serious incidents and they probably didn't call" her about the 3/8/09 one. E1 could find no documentation that she had been notified of the possible sexual, mental and emotional abuse towards R1 on 3/8/09.

2) According to the physician's notes dated 6/1/09 to 6/30/09, R2 is a 65 year old male with diagnoses of Mild Mental Retardation, Depression, Dementia and Impulse Control Disorder.

R2's ICAP of 10/6/08 shows that R2 functions overall at 4 years, 1 month. The Maximum Growth Potential Plan dated 10/21/08 states R2 "has engaged in sexual behavior without the others consent once a year."....."it is speculated that (R2) has went after another resident for sexual gratification".

The following incidents were documented on the behavior notes found in R2's chart:

1/25/09 - 7A - 3P shift: Staff heard a resident yelling in the men's bathroom. The bathroom door was open part way and staff saw R2 with his hand down R1's pants. "Rest of afternoon checks was randomly done."

2/18/09 - 2P - 10P shift; "Staff was walking down hallway and observed R2 looking at another resident (not identified) whose door was open and getting dressed." Staff counseled R2 about the inappropriateness of his actions.

CONT.

2/26/09 - 3P - 11P; "A resident (R7) came to staff and told them that while he was in the shower (R2) came into the restroom and pulled the curtain open and stared at him (R7) while showering." Staff again counseled R2 about the inappropriateness of this behavior.

3/7/09 - 9:15 P.M. Staff heard a male resident (R3) yell "no!" Staff observed R2 sitting next to R3 "with his hand rubbing (R3's) leg. (R3) then said 'stop - don't mess with me!' and moved down the couch away from (R2). (R2) still persisted and rubbed his hand along the couch towards (R3's) buttock area." Staff prompted R2 several times before he left the couch. R2 was counseled about his inappropriate actions.

3/8/09 - 3P - 11P; R1 was heard yelling from the men's bathroom and then observed running out of the bathroom carrying his pants. R1 said R2's name when staff asked R1 what happened. "The third client (R6) informed staff that (R2) was acting sexually inappropriate with the yelling client (R1)." When staff counseled R2, R2 denied the incident, and then staff referred to "previous incidents of sexual inappropriateness with R1." R2 said "I know I shouldn't do that stuff."

5/9/09 - 10:25 P.M. Staff heard R1 yelling in the bathroom and observed R2 with his pants down. Staff asked R2 if he had done something to R1 and "he informed staff that he had."

5/10/09 - 3P - 11P; R2 told E2 that he wanted to talk to E2 about the incident from the day before. R2 stated "I saw (R1) in the bathroom standing at the toilet.....I went in, stood behind him, took my pants down, and stuck my thing in his butt." R2 also said R1 "doesn't like me doing that but I do it anyway, and I was told I can't do that to him". R2 repeatedly told E2 he wanted to go to jail for what he did and asked E2 to call the police.

5/17/09 - 3P - 11P; R2 "continually stared at another client (R1) and made him yell. He was prompted to stop but wouldn't comply."

In an interview with E2, Activity Director, on 7/27/09 at 3:00 P.M., E2 said R1 is non-verbal and R2 targets him. R1 would not sit by R2 and always wanted to know where R2 was. E2 also said R1 would not go in the bathroom if R2 was in there.

E3, DSP, was interviewed on 7/27/09 at 2:15 P.M. E3 said R1 did not like to be in the same room as R2, noting that R1 would scream and staff had to keep them apart. E3 stated R2 often patted R1 on the bottom and R1 tried to avoid R2.

E1, Administrator and QMRP (Qualified Mental Retardation Professional), was interviewed on 7/27/09 at 10:15 A.M. E1 confirmed the facility had only one allegation of abuse which occurred on 5/9/09 between R1 and R2. When asked if there were any prior incidents involving potential abuse by R2 directed toward R1, E1 said there "may have been. I will have to review the behavior reports."

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E1 explained that most incidents/accidents are documented on each client's behavior notes which E1 reviews at the end of each month for her QMRP reviews. E1 said allegations of abuse or neglect are not looked at by any committee, confirming that a Human Rights/Behavior Management Committee had been held on 5/27/09 but the incident of 5/9/09 was not discussed. E1 also said the facility does not have a Quality Assurance Committee or a Safety Committee that monitors incidents/accidents.

During this interview, surveyor asked E1 if she is notified of every incident of possible abuse or neglect and client to client aggression. E1 said for "serious ones, staff call me," but the others she would see at the end of the month. E1 confirmed that she did not do an investigation for any of the above incidents, only the one on 5/9/09.

According to the facility's investigative report of 5/9/09, the incident occurred at 10:30 P.M. The report states R1 "was urinating facing toilet, another male resident (R2) came into the bathroom and his penis touched the other resident's buttocks. R1 yelled and a staff came into the male bathroom & witnessed both men with their pants down but not touching each other." The facility concluded R2 "did try sexual physical contact that did not involve penetration," that the facility's nurse examined R1 and "determined there was no physical harm."

Per review of the nurse's notes, R1 was not examined by the facility nurse until 5/11/09 when she conducted a "full skin assessment." When R1 was also seen by his psychiatrist on 5/11/09, the psychiatrist recommended "these two individuals (R1, R2) be moved as far from each other as possible." R1 was not examined by his physician until 5/12/09.

R2 was assessed by the psychiatrist on 5/11/09. The psychiatrist noted that R2 admitted to the sexual incident of 5/9/09, documenting "there have been suspicions of pt (patient) trying other acts (with) other peers prior to this." The psychiatrist recommended "Room changes ASAP to separate (R2) from (R1) as far as possible & notify victim's guardian NOW."

E8, SSD (Social Services Designee), was interviewed on 8/5/09. E8 confirmed that room changes did not occur until 5/11/09 after the psychiatrist recommended that R1 and R2 be separated.

According to the facility's investigative report for the 5/9/09 incident, R1 was put on "1:1 to keep resident safety." However, per review of the facility's staffing schedule, no additional staff was put in place. The incident happened at 10:30 P.M. on 5/9/09 which was a Saturday. At this time, only 1 staff was on duty from 10:00 P.M. to 6:00 A.M. Review of the May and June's schedules show there always is just one person scheduled from 10:00 P.M. to 6:00 A.M.

E1 was interviewed on 7/28/09 at 2:00 P.M. E1 confirmed that no extra staff was added after the incident and that existing staff were expected to monitor R1 and R2.

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Per interview with E1 on 7/28/09 at 9:15 A.M., R1 and R2's bedrooms were located side by side. The only way R1 could go to the men's bathroom or to access any other part of the facility was to go past R2's bedroom. E1 confirmed that R2 was not moved away from R1's area until 5/11/09.

Regarding R2's incidents of inappropriate sexual behavior from 1/3/09 to 5/17/09, surveyor found 10 incidents, 8 of which occurred on second shift (3P - 11P) and 6 of 10 incidents occurred on weekends. Surveyor could find no evidence that the facility investigated each incident, interviewed staff and residents, and assessed staffing needs and room assignments to ensure clients' safety.

3) Review of physician's orders dated 6/1/09 - 6/30/09 shows R3 has diagnoses of Moderate Mental Retardation and Post Traumatic Stress Disorder with Depressive Mood.

An ICAP dated 10/20/08 reflects R3 functions at the overall level of 4 years, 6 months. According to the Maximum Growth Potential Plan of 10/20/08, R3 has been assessed with an IQ of 37 and has been a "victim of sexual abuse. He lacks the ability to say no and walk away if someone was to sexually assault him."

Incidents of R3 being verbally and physically aggressive towards residents and staff were documented in R3's behavior notes on 1/9/09, 1/11/09, 1/13/09, and 1/18/09. Staff also documented an incident of R3 biting his arm during an altercation with staff on 1/18/09. On 1/25/09, E2 documented that she asked R3 if "something was bothering him. He first said nothing was wrong. Staff explained to (R3) they were concerned because he hadn't been acting like himself lately." R3 said "I hate (R4)." E2 asked R3 why he hated R4 and R3 said "he is bad."

At this point, E2 asked another direct care staff (E6) to come to the bathroom where E2 was assisting R3 with his shower, noting E6 had an especially good rapport with R3. E6 asked R3 what R4 "does that you don't like? (R3) replied 'He puts his d*** in my mouth and it taste really bad.'" R3 said this happened in the bathroom but did not indicate when it happened.

On 3/7/09 at 9:15 P.M., staff documented that they heard R3 yell "no" from the living room. Staff observed R2 sitting next to R3 "with his hand rubbing (R3's) leg. (R3) then said 'stop - don't mess with me!' and moved down the couch away from (R2). (R2) still persisted and rubbed his hand along the couch towards (R3's) buttock area". Staff had to prompt R2 several times before he left the couch.

Per review of psychiatric notes for R3 dated 3/13/09, R3 was taken for a psychiatrist visit due to "increase in verbal and physical aggression. Throwing items. Has been threatening to kill himself on the bus ride home (from day training) several times per week. Non-compliant with ADL's. Won't get dressed, take bath."

CONT.

No documentation could be found in R3's chart showing incidents of threatening suicide. No evidence could be found showing the facility had informed R3's guardian of the allegation of sexual abuse.

E1 was interviewed 7/28/09 at 9:00 A.M. E1 said she knew about the allegation R3 made against R4. E1 said she talked with both individuals, got two different stories and there were no witnesses. E1 confirmed that she did not investigate the allegation, did not report the allegation to R3's guardian or to the Illinois Department of Public Health, or take corrective action.

E3, DSP, was interviewed on 7/27/09 at 2:15 P.M. E3 said she has never known R3 to make false allegations. E3 stated she would take any allegation R3 made "very seriously."

E5, DSP, was interviewed on 8/3/09 at 4:50 P.M. E5 stated she has never known R3 to make things up. E5 stated she noticed R3 "acting differently" around R4 for a few days. E5 said staff had to move R4 away from R3 before because R4 was getting "handsy" with R3.

E6, DSP, was interviewed on 8/4/09 at 2:15 P.M. E6 also said she has never known R3 to make false allegations, stating that R3 "just doesn't make things up."

During continued interview with E1 on 7/28/09, E1 confirmed R3 had not been assessed for injury by the facility nurse or physician and had not been tested for sexually transmitted diseases.

E1 said she never heard R3 threaten suicide to her, stating the incidents occurred on the day training bus. E1 said workshop staff would tell facility staff about R3's comments but did not always send an incident report. E1 said she was not personally contacted by day training staff about R3's behaviors.

Z1 was interviewed on 8/3/09 at 12:20 P.M. Z1 said she drives a day training bus and noticed R3's behaviors had changed sometime in early 2009. Z1 explained R3 was observed hitting/biting himself, hitting the bus windows and yelling "shut-up" to no one in particular. Z1 said this behavior occurred mostly in the evenings on the ride back to the facility.

Telephone interview with Z2 on 8/3/09 at 10:50 A.M. confirmed she also drives a day training bus and was normally the evening driver. Z2 said R3 "hollered a lot and said he would kill himself." Z2 said she told her case manager who notified the facility and implemented a tracking system and also implemented a goal to address R3's yelling. Z2 said R3's behavior was definitely out of the ordinary.

Surveyor reviewed day training's tracking forms and documentation for R3. On 2/11/09, R3 began yelling before the bus left the driveway at day training. R3 was yelling at unidentified consumer and stated repeatedly "I'm going to kill myself." Documentation shows day training staff called the facility to report the incident. The report shows day training staff (Z6) spoke with

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E8, who "said there have been some issues at home that may be a significant factor in (R3's) behavior. They are being addressed by (name of facility) staff."

According to the incident report, on 2/12/09, the former QMRP/Case Manager for R3 at day training (Z7) reviewed the report, spoke with R3, noted he was much calmer, and noted that both the day training staff and facility staff "will continue to monitor and keep informed."

Per day training incident report dated 3/5/09 on the bus ride home from day training, R3 "started yelling and hitting himself very hard & stomping then said 'I'll kill myself',' continuing to yell during the ride home."

Z7 began to record incidents, both during the a.m. and p.m. routes on the day training bus for R3. Copies of the tracking records were available from 2/23 to 3/20/09. No incidents of R3 threatening to kill himself occurred on the morning drive to day training. However, during the return trip to the facility in the evenings, R3 had several incidents of yelling, threatening suicide, hitting himself and hitting others. Documentation shows incidents of R3 threatening to kill himself declined after 3/5/09, but hitting himself continued for another week.

Z7 documented that she called the facility on 3/5/09 and spoke with E1. "We discussed the increase in behaviors that (R3) has had on the bus lately, as well as his statements of 'I'll kill myself.'" Z7 documented that she was going to write a program "addressing this issue."

During an interview with Z8 on 8/3/09 at 12:55 P.M., Z8 said "it was not like (R3) to make suicidal statements." Z8 said she and Z7 talked with R3, but R3 would not say what was bothering him. Z8 said she remembers Z7 keeping tracking logs to establish a baseline of R3's behavior, noting that they usually occurred on the ride home from day training.

4) Per review of physician's orders dated 6/1/09 - 6/30/09, R4 is a 23 year old male with diagnoses of Mild Mental Retardation, Depression, Intermittent Explosive Disorder, and Impulse Control Disorder.

The ICAP, dated 3/23/09, reflects R4 functioning at an overall age equivalence of 9 years 11 months.

According to the psychiatrist's consultation notes dated 2/20/09, facility staff noted that R4 had been experiencing a major increase in verbal and physical aggression towards staff and "accusations of sexual activity with two males and one non-consenting male client all within a few weeks of each other." However, no documentation was found in R4's chart regarding these accusations.
A document titled QUARTERLY ASSESSMENT in R4's chart, dated April 2008 to April 2009 shows that "there were several accusations of sexual abuse this quarter (1/09 to 3/09) from some of the other clients." Again, no documentation of these accusations was found in R4's record.

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There is no evidence that the administrator was immediately notified of these allegations and no evidence that an investigation was conducted or safeguards put in place.

Per review of R4's Maximum Growth Potential Assessment dated 3/24/09, R4 does not "display only appropriate touching," does not refuse "inappropriate expressions of affection," does not allow others "to refuse inappropriate expressions of affection," does not differentiate "between places which are appropriate and places which are inappropriate locations for touching other people," is not "aware of difference of 'good touch and 'bad touch,'" is not "aware of both heterosexuality and homosexuality," and is not aware of topics such as "family planning and marriage."

Additionally, the Maximum Growth Potential Assessment shows R4 does not take "precautions to prevent sexually transmitted diseases," does not recognize "symptoms of sexually transmitted diseases," and does not identify inappropriate "advances which are exploitive, illegal and unacceptable sexual behaviors."

Review of R4's Individual Program Plan (IPP) dated 4/9/09 shows that R4 is not on any type of sexuality education, either formally or informally.

An interview with E1 on 8/5/09 at 2:20 P.M. confirmed R4 is not receiving sexuality training at the facility. E1 said R4 will not talk about sexual issues. E1 said she has not implemented a social/sexual educational objective with R4.

In addition, R4 has not been tested for sexually transmitted diseases since 4/30/07, according to lab results provided by the facility.

Interview with E1 on 7/28/09 confirmed E1 reviews the observation notes, incidents, and behavior notes at the end of the month for each resident as she does her QMRP progress notes. E1 said she really had not evaluated them for trends or patterns. E1 also said R3 and R4's bedrooms were situated adjacent to each other and R4 had not been moved until 5/11/09.

5) Per review of the facility's reports titled INCIDENT REPORT FORM - IDPH NOTIFICATION dated 9/07/09; R7 "inappropriately touched another resident - report to follow." This incident report documents under the category of ALLEGED ABUSE "Sexual Inappropriate touch." This report states the local police were notified, that R7 was taken to a local hospital Emergency Room (E. R.), and he was seen by a physician.

An incident report dated 9/07/09 was reviewed and it states R15 was "sent to (E.R.) for an evaluation after being touched inappropriately." This report indicates that R15 was also seen by a physician in the ER and that the police were notified.
The facility's final report of this incident states, "(R7 and R15) were in their bedroom. This was 9/7/09 between 9:00-9:30 P.M.... (R7) touched (R15) inappropriately without (R15's)

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permission. The investigation is ongoing pending police reports, states attorney, psychological, and judge. (R7) has been on 1:1 24/7 since the incident."

According to a facility report, titled Behavioral Incident Report For Targeted Resident dated 9/7/09, R15 is listed as the targeted resident. Another Behavior Incident Report, dated 9/7/09, documents type of incident as "Maladaptive Behavior W/Inappropriate Sexual Behavior," and R7 is listed as the perpetrator. This report continues to state that R7 "sexually assaulted his roommate," R15 at 9:00 P.M.

These reports list E6/Direct Support Person (DSP) and E2/DSP/Activity Director as the facility staff who became aware of the incident, and E7/DSP as the staff that transported R15 to the local hospital E. R. after the assault. E2 took R7 in another facility vehicle to the same E. R. after Z10 and Z11 (local sheriff deputies) responded to the facility's call.

E6's undated written statement states, "I saw (R15) come down the hallway running holding his privates with his shorts down around his ankles at 9:00 P.M. I assumed he had just gotten up from sleeping and I redirected him to the men's bathroom. He was already incontinent so I had him go to his bedroom where I picked him out some dry clothes. I changed his sheets and had him sit on his bed while he changed his clothes. I had him help put on his sheet when I temporarily left his room to get a top sheet for his bed. When I came back to his room only a couple of minutes later (R15's) roommate (R7's initials) told staff to not come in. Staff assumed he was changing his clothes. Another staff was on telephone and asked me what (R7) said. I told her he told me to not come in. I had closed the door to (R15's) room. Staff (E2) asked me to open the door and check on (R15). I opened the door and saw (R7) lying naked on his bed and (R15) was putting his sheet on his bed. I asked staff (E2) to please come and speak with (R7). I heard (E2) ask (R7) what he was doing with his clothes wadded up under his covers.....He told (E2) that he was masturbating and he needed a shower...."

The statement continues to say that E2 asked E6 if she thought something was not right about the situation. E2 then asked R15 if R7 had touched him and R15 "hung his head down." E2 then went to question R7, and E6 talked with R15. When E6 asked him if "(R7) had touched his private he then looked at me and told me yes." E2 then returned to E6 and said that R7 had "confessed to her that he had touched (R15's) private and had attempted having sex with (R15)."

The Behavioral Incident Report For Targeted Resident regarding R15 documents R15's guardian, his sister, was notified at 9:30 P.M. on 9/07/09, and she "wanted charges pressed against assaulter and have (R15) checked out."

E12/R.N. (facility's Registerd Nurse) was contacted on 9/7/09 at 9:40 P.M. by E2. E12 told her to take R15 to the E.R. and to keep him away from R7.

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The Behavioral Incident Report regarding R15 states that at 11:00 P.M. R15 accompanied by E7 "left facility and transported to (name of local) E.R. A sexual assault kit was completed and a SAFE agent talked with (R15)."

E1, the Administrator and Qualified Mental Retardation Professional (QMRP) of the facility, told the surveyor on 9/15/09 at approximately 9:15 A.M. that she had conducted an investigation of an allegation of sexual assualt by R7 towards R15. She said the assault occurred at 10:00 P.M., and that she interviewed R7 on 9/8/09. E1's written statement of her interview with R7 states, "(R7) came into my office and asked me if I wanted to know what he did. I advised him I would like to know. He said that his roommate came over to him; he pulled his pants down, and put his mouth around his penis and his roommate backed away...I asked him why he did it and he stated because I miss my ex-boyfriend. I also asked him why he has been laughing about the situation, he stated because he was mad at his ex-boyfriend for not having anal sex when he asked him."

E1 said, during this same interview, that she attempted to interview R15 about the episode, but he did not respond to her.

On 9/15/09 at approximately 3:20 P.M., E2 said she accompanied R15 to the local E.R. after the police finished their interviews at the facility with the two clients and the staff.

According to her written statement dated 9/8/09, R7 told her that he "told (R15) to come here and he walked to my bed. I grabbed hold of his d..k and he pulled away and went out the door." E2 said she asked R7 how R15's pants got pulled down and that R7 said "I pulled them down as I was grabbing his d..k." Then when R7 was on the way to the hospital he started to tell E2 again about what had happened. He said, "he had touched (R15) on his d..k." When she asked R7 if anything else happened, he told her "he had laid on (R15) and rubbed (R15's) d..k on mine." E2 asked R7 if R15 tried to get away from him and he said, "That’s why he ran out the door and down the hallway." E2 said R7 laughed and smiled with every question she asked him and told her he was laughing because "it's all funny."

On 9/15/09 at approximately 1:50 P.M., E6 said that she now believes "R15 was running from his room with his underwear around his ankles because he was coming to the staff for help." She told the surveyor on 9/16/09 at approximately 2:00 P.M. that R15 had been moved into R7's bedroom about a month ago because his prior roommate, R14 had been bossy to R15.

During an interview with R7 on 9/16/09 at approximately 4:43 P.M., he told the surveyor that he had tried to change R15's wet clothing. R7 said he was in his own bed and he called R15 to come over to his bed. "I was thinking of (R4) and (R15) was wet and up walking in the room. I called him to over to me in bed." He said he had just put his mouth on R15's "d..k" when R15 pushed him away. "(R15) did not want me to do this and he pushed me away." R15 then left the room

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and R7 said he then masturbated. R7 said, "I like boys and big "d..ks." He asked if he was going to go to jail.

On 9/16/09 at 4:25 P.M., the surveyor attempted to interview R15. He shook his head "yes" when he was asked if R7 had touched his penis. R15 also shook his head "no" when asked if he wanted R7 to touch his penis. He did not respond to the surveyor when asked if R7 had put his penis into his mouth.

The police report written by Z10 regarding this sexual assault of 9/07/09 documents R7 stated that he and R15 had sex tonight at approximately 9:00 P.M. in their room. R7 said he performed oral sex on R15, and R15 did not want him to and told him to stop.

According to a Psychological Consultation Report dated 4/21/09, R7 is functioning in a Moderate Level of Mental Retardation and has an Intelligence Quotient of 48. The Medical Examination report dated 3/31/09 lists R7 as being 23 years of age and having diagnoses of Bi-polar, Post Traumatic Stress Disorder and Anti-social Traits.

The Inventory for Client and Agency Planning (ICAP) assessment dated 9/08/09 documents that R7 is functioning in an age equivalent of 8 years and 9 months.

The Psychological Consultation Report documents that "(R7) has a formal Behavior Program that addresses the maladaptive behaviors of elopement, anxiety, non-compliance, verbal aggression, inappropriate touch, manipulation/lying, and incontinence... His "inappropriate touch" is defined as "touching, kissing, hugging, rubbing, or speaking to staff or peers in an inappropriate manner." His "manipulation/lying" is defined as "will tell each staff different stories to get the outcome he wants."

A Physician Referral Sheet regarding R7 and dated 3/13/09 states the reason for consultation with Z9/Psychiatrist: "Inappropriate touch and comments to staff and clients. Also several incidents of inappropriate sexual touch with other clients. Several incidents of putting his tongue inside the dogs mouth and letting the dog lick his tongue. Constantly argumentative, intrusive, and often verbal with everyone in facility. Elopement when 'bored.'"

R7's Behavior Management Program (BMP) dated 8/19/09 addresses verbal aggression, noncompliance, attention seeking behavior, elopement, lying and manipulation, and sexual inappropriateness.

The BMP states that "(R7) moved to (name of this facility) on 1/2/06...(R7) often tries to play the role of the victim and will on occasions make up stories about others just to get them in trouble or to keep him out of trouble. If he does not like someone he will do whatever it takes to get the other individuals in trouble... There is a male client who lives at the facility who at one time (R7) had a consensual sexual relationship with. (R7) and the male broke up and he continues to have

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an obsession with this male client...He will follow the client around to the point the other client becomes extremely frustrated with him.

When a new client moved into the facility in May 2009, (R7) wanted to have a consensual sexual relationship with this new male. (R7) stated he wanted to marry this new male resident and would hold the new client's hand. When the other client was asked if he wanted to have a relationship with this client, he stated that he did not....(R7) then began starting problems with this client and tried to get his former boyfriend in on it as well....(R7) is bisexual however seems to prefer having relationships with males. When a new client comes into the facility and is close to his age he will try to persuade the other client to have a relationship with him...(R7) currently has door alarms on his bedroom door that notify staff if he has left his room. These alarms have been placed on his door due to his elopement/elopement attempts and sexually inappropriate behavior."

The BMP discusses R7's sexually inappropriate behavior to include touching, kissing, rubbing, or speaking to staff or peers in an inappropriate manner. He will interact with other male clients in an over friendly manner and will place his hand on the other client's leg.

According to the (QMRP) monthly reviews, R7 displayed 0 incidents of verbal aggression, 2 incidents of inappropriate touch, 73 noncompliance, and 7 incidents of lying/manipulation during the month of July in 2009. Then for the month of August of 2009, the number of R7's maladaptive behaviors increased to 37 incidents of inappropriate touch, 285 incidents of noncompliance, 50 verbal aggression incidents, and 78 incidents of lying/manipulation.

The Quarterly Assessments completed by E8/Social Service Designee and dated 4/09 and 7/09 state that "(R7) continues to have issues with another client with whom he had a relationship with... The other client is very rude to (R7) and has stated for almost a year that he does not want to be friends. The only time the other client acknowledges that (R7) exists is when he would like to be satisfied sexually."

The April 09 quarterly assessment report also documented that R7 "had numerous incidents of inappropriate touch with staff and clients and standing naked in front of his door way or hallway. He also had several incidents of being sexually inappropriate with two of the male clients."

R15 is functioning in a Moderate Level of Mental Retardation according to a Psychological Evaluation Report dated 6/22/09. This report list additional diagnoses of Seizure Disorder and Chromosomal Abnormality of Partial Trisomy 7Q. R15's Admission Record lists his admission date to the facility on 4/28/09 and that he is 39 years of age. According to the Psychological Evaluation Report, R14's present testing by a Slosson intelligence Test estimates his IQ at 40.

The Psychological Evaluation Report states that an ICAP dated 5/29/09 indicates R15's age equivalent is 2 years and 8 months, and "(R15's) overall level of adaptive functioning is

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profound/severally limited, based on his Broad Independence Age Equivalent." The report documents, "(R15) displayed markedly deficient ability for engaging in abstract thinking. In addition, his judgment seemed extremely limited. He did not express any insight regarding personal strengths and weaknesses."

This report states "it should be mentioned that (R15) evidenced a noticeable decline of 3 years 8 months in his overall adaptive functioning, from the standpoint of comparing the most recent ICAP Broad Independence age scores with those from the 2005 assessment. The previously captioned declines in adaptive functioning could be largely due to the consumer's apparent chromosome 7q disorder."

Further information in this report regarding the diagnosis of Chromosomal Abnormality of Partial Trisomy 7Q, documents that this is an inherited genetic condition. "Persons with the chromosome 7q disorder typically exhibit developmental delays and mental retardation of varying degree. The chromosome 7q disorder can be progressive and resemble dementia, because of the cognitive decline that is noted."

The report states "(R15's) immediate, recent, and remote memory capacities could not be adequately evaluated, because of his seemingly non-verbal nature during this session. It should be noted that he drooled throughout the assessment session."

A Physician Referral Sheet dated 6/19/09, sent to Z9, R15's Psychiatrist stated, "(R15's) most prominent behaviors are stealing food, drink, and items belonging to others. And masturbating/rubbing penis in public. R15) needs constant supervision due to wandering." Z9 wrote on the referral regarding R15, "Functional deterioration last several months, quite pronounced."

R15's 30 day Individual Disciplinary Team (IDT) met on 5/29/09. The report submitted by a DSP (no name signed) and dated 5/29/09 documents that R15 "spends most of his time walking around the facility. This leads to him going into other clients rooms and messing with their things, He doesn't talk very often and rarely answers staff when asked a question...requires several vp's (verbal prompts) to get him to comply w/staff's requests... He is incontinent a lot and frequently urinates on the floor and his bed (on purpose). He also masturbates in inappropriate places." I recommend as much one on one as possible. He needs a lot of redirection. Also to prevent elopement."

Review of R15's program goals and progress dated 7/13/09, he is on a behavior program to exhibit 6 or less incidents of socially offensive behavior per day. From 5/11/09 -6/11/09 R15 exhibited 15 incidents of putting his hands inside pants at Day Training (DT). From 6/11/09 - 7/11/09, he displayed 11 incidents of hands in pants and from 7/11/09 - 8/11/09 9 incidents of hands in pants at DT.

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According to the facility's QMRP monthly progress notes from of 7/1/09 to 7/31/09 R15 had 7 incidents of inappropriate sexual behavior.

On 9/08/09 E1 conducted a SAFETY/RISK ASSESSMENT on R7. She wrote "(R7) requires a 1:1 staff at all times. He is not appropriate or safe to be alone. (R7) must have a roommate who is able to express wants/needs and can protect themselves from unwanted advances."

R15's strengths and weaknesses are discussed in the QMRP's Maximum Growth Potential Plan written about R15 on 5/29/09. This was prepared by E1 for R15's IDT. Under the area of Sexuality, E1 wrote,"(R15) could be victim for sexual abuse due to his verbalization."

E1 conducted an assessment titled SAFETY/RISK ASSESSMENT on 9/08/09 about R7. She wrote "(R7) requires a 1:1 staff at all times. He is not appropriate or safe to be alone. (R7) must have a room mate who is able to express wants/needs and can protect themselves from unwanted advances."

6) According to the undated facility roster, R14 functions at the mild level of mental retardation. Facility records show R14 was admitted on 5/18/09 and his 30 day staffing was held on 6/18/09.

The observation notes written by direct care staff show R14 exhibited the following behaviors from 5/27/09 to 8/2/09: R14 left the facility for a home visit on 8/4/09.

5/27/09 - 3P - 11P shift; R14 repeatedly threatened to hit R4. R14 did not respond to verbal prompting from staff to quit harassing R4 and continued this verbally aggressive behavior throughout the evening.

5/27/09 - 2P - 10P; R14 was "verbally abusive to other clients." These individuals were not identified.

5/30/09 - 7A - 3P; as staff walked into the dining room, "saw (R14's) hand on another resident's (unidentified) knee."

6/9/09 - 11A - 9P; R14 "was lying down and had his arm lying in other male resident's lap." Both residents were on the couch.

6/10/09 - 2P - 10P; R14 made several sexual comments to staff, asking female staff if she "liked looking at men's privates and if staff would have sex with a resident."

6/12/09 - 2P - 10P; R14 was sitting by another resident (not identified) when staff heard the resident tell R14 "stop that." R14 said he was "putting his lips against the other resident drooling on him."

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6/15/09 - 6A - 2P; R14 made several sexual comments to staff.

6/18/09 - 11P - 9A; R14 intimidated R15 and became physically aggressive with R15. According to the room assignment sheet, R15 is R14's roommate. (Per facility roster, R15 functions at the severe level of mental retardation.)

6/19/09 - 6A - 2P; R14 was sexually inappropriate with staff - "kissing and licking staff on the face and hands," then became physically aggressive when staff told R14 to quit. "Five minutes later while trying to get another client's (R7) attention, (R14) hit (R7) in the privates." (Per facility roster, R7 functions at the mild level of mental retardation.)

6/19/09 - 3P - 11P; R14 became physically aggressive with residents, hitting the dining room table and throwing a chair. R14 also "got up in one client's (R7) face" and threatened to strike R7.

6/19/09 - 6A - 2P; R14 tried to hit another client with the seat belt while in the van. "The behavior escalated and he began hitting the van windows & roof."

6/23/09 - 6A - 2P; R14 called R9 names. R9 "was very upset." (Per facility roster, R9 functions at the mild level of mental retardation.)

6/26/09 - 2P - 6P; While coming home from workshop, R14 hit another client (R12) who "started to cry." Staff looked at R12's back and "noticed a red mark." (R12 functions at the moderate level of mental retardation.)

6/27/09 - 3P; R14 complained that R12 would not speak to him. Staff told R14 that it was probably because of the incident the previous day. R14 "then said he would kill (R12) with a knife." Staff counseled R14, but R14 "continued to make threats of hitting & raping staff. He was also cursing at staff & flipping them off."

7/1/09 - 2P - 10P; R14 "cussed staff and other clients. He lay on another client (R13) on the couch. (R13) asked (R14) to move off of her and he cussed her. (R14) refused to stop or leave the area." (R13 functions at the severe level of mental retardation.)

7/2/09 - 6A - 2P; R14 "began cussing clients and staff for no apparent reason. He then spit on the couch several times. (R14) then began to single out certain clients (R4, R7, R9, R12, R13) trying to cause them to have behaviors by cussing & threatening them."

7/2/09 - 2nd shifts; R14 "cussed clients, knocked over a chair, clawed at couch & threatened to take his pants off."
7/3/09 - 6A - 2P; R14 had "a very poor day. His behaviors ranged from inappropriate sexual behavior, intimidation, verbally aggressive, lying/manipulation, physical aggression."

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7/4/09 - 3P - 11P; R14 "tried several times to kiss staff and other residents" (not identified).

7/5/09 - 7A - 3P; R14 "began touching another client (R15), then began to pinch another client" (R6). R14 was redirected but became verbally aggressive towards clients and began to hit the couch and throw his shoes. R14 "kept saying he would burn down the facility & call the cops. He cussed everyone out. This continued for about 1 1/2 hours." (R6 functions at the profound level of mental retardation and uses a walker for ambulation. R15 functions at the severe level of mental retardation.)

7/5/09 - 3P - 11P; R14 "was verbally aggressive with two other clients" (R4, R7).

7/12/09 - 1st shift; R14 "began picking on other clients .....He didn't want other clients sitting on the couch. (R14) began threatening to kick/hit clients & break items." (Clients who were threatened were not identified).

7/12/09 - 2nd shift; R14 "was very physical aggressive toward other clients (not identified)" and later was also verbally aggressive.

7/14/09 - 6A - 2P; R14 made several sexual comments to staff, stating he was going to say she "raped him." After staff counseled R14 about this being inappropriate, R14 grabbed R15 "and was hugging him very tight." After several prompts, R14 released R15 and started hugging staff stating he wanted her to "kiss him on the lips."

7/14/09 - 2nd shifts; R14 "was aggravating others by being sexually inappropriate, making inappropriate hand gestures, & making verbal threats."

7/16/09 - On the bus ride home from day training, R14 hit R13 on the leg because R13 sat down beside R14. R14 also threatened to break R4's sunglasses. R14 "was cussing and threatening staff, stating he was going to get a gun and shoot staff."

7/17/09 - 2nd shifts; R14 was "very volatile. He began threatening & bending his silverware & threatened staff that he was going to stab her with a fork." R14 was physically taken to his room and when staff started to counsel him about his behavior, R14 "jumped off his bed & lunged at staff." Staff had to use Crisis Prevention Intervention (CPI) techniques to get him to calm down.

7/18/09 - 3P - 11P; around supper time, R14 began to threaten residents and was verbally aggressive. He kicked R7 in the side. R14 continued this behavior for about 20 minutes. At approximately 8:00 P.M., R14 "began his behaviors again." R14 threatened to hurt others, was verbally aggressive, spit on the floor and screamed obscenities.

7/19/09 - 2P - 10P; R14 became verbally and physically aggressive to residents. "He hit and kicked (R15), scratched (R4) and threw his shoe hitting (R11). (R11 is an 80 year old female

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who functions at the severe level of mental retardation and uses a wheelchair for all her mobility needs.)

7/22/09 - 6A - 2P; R14 purposely aggravated another client into threatening him with P (physical) Violence."

7/24 - 7/25/09 - Staff documented several instances of R14 trying to hug and kiss others, who are not identified.

7/31/09 - 6A - 2P; R14 "has been counseled several times" and his "behaviors have been occurring all day." R14 hit staff in the stomach, made false allegations about residents and staff,. R14 also lay on the couch in his shorts with an erection, preventing other residents from using the couch.

8/1/09 - 4:20 P.M.; R14 kicked another client (R7), "flipped off" other clients, and yelled profanities at other clients. The clients in the living room at this time were R4, R5, R6, R7, R10, and R13. (R5 functions at the profound level of mental retardation, has a broken right arm and is seated in a wheelchair.)

8/2/09 - 11:25 A.M. R14 "began to say rude things to and about several clients, he was trying to start arguments. He then began to flip others off, curse @ everyone & hit the couch. He also began to threaten others. He attempted to knock a mirror off of the wall by hitting it." Staff had to physically remove R14 from the dining room. Residents present include R3, R4, R5, R6, R7, R9, R13, R15, and R16. (Per facility roster, R16 functions at the severe level of mental retardation.)

8/2/09 - 12:30 P.M. R14 came into the dining room "and started mouthing residents and staff. Then he was threatening to kill everyone and burn down homes." R14 sat on the couch and started harassing R4 which began a verbal altercation between R4 and R14. R14 "got up and threw (R6's) walker." Residents in the room at this time include R7, R10, R13, and R16.

E1 was interviewed on 8/5/09 at 2:20 P.M. Surveyor asked E1 about the facility's prescreening protocol and what kind of information about R14 was reviewed prior to being admitted to the facility. E1 said she did the "pre-screen per observation while R14 was visiting." E1 said she did not have much information on R14, just some old observation notes, but she got more information when she went to the facility to pick R14 up. E1 said she was the only one who pre-screened him, noting that R14 did well during his initial visit. E1 confirmed that she did not have all the information and assessments for R14 before he was admitted to the facility.

Review of R14's chart shows some documents that were not received by the facility until 7/6/09 when they were faxed from the prior placement include physician's notes, dated 2/2/09. The physician described R14 "as being aggressive, threatening to rape female residents, threatening

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to burn down the facility, etc."

According to this physician's assessment, R14 has "Attention-deficit/hyperactivity disorder, schizoaffective disorder with suicidal, homicidal, aggressive and sexual predatory ideation, along with Anxiety disorder."

Surveyor asked E1 if R14 was on a behavior plan to address the verbal and physical aggression, the intimidation, and the sexual inappropriateness. E1 said they were "using the same behavior plan (R14) came in with."

Review of R14's behavior plan which is dated 3/9/09 shows the maladaptive behaviors to be addressed is Intimidation and Suicidal Threats. This behavior plan does not define intimidation, whether or not it includes verbal and physical aggression, threats to kill others, to burn down the facility or what psychotropic medication R14 takes. The plan also does not address R14's sexually inappropriate behaviors.

According to the available behavior notes, R14 had 4 incidents of verbal aggression and sexually inappropriate behavior towards residents and staff in May of 2009, 12 incidents of verbal, physical and/or sexually inappropriate behaviors towards residents and staff in June of 2009, and 25 incidents of verbal and physical aggression which included threats to kill others, to burn the house down, and also sexual inappropriateness to residents and staff during July of 2009.

During continuing interview with E1 on 8/5/09 at 2:20 P.M., E1 said R14's behavior plan has not been updated and does not address R14's steady increase in verbal/physical aggression or sexually inappropriate behavior since he was admitted to the facility.

E1 also did not confirm that the incidents of R14's aggression towards other individuals residing in the facility were reported to the Illinois Department of Public Health or investigated; nor were patterns and trends of incidents assessed.

In addition, on 8/3/09 surveyor asked E1 for documentation showing that the two new admissions (R6 and R14) had been screened on the sex offender background check. E1 said she had not checked the Illinois State Police (ISP) sex offender background site for R6 and R14. On 8/4/09 at 8:20 A.M., E1 presented the ISP sex offender checks for all clients (R1, R3 - R16), stating none of the individuals had been previously screened. .

According to the facility's policy titled Abuse Prevention Program, dated 3/5/09, sexual abuse is defined as, but not limited to, "sexual harassment, sexual coercion, or sexual assault". The policy states that at "least quarterly, the Quality Assurance Committee will review accident reports, incidents reports.....and safety committee reports to assess possible patterns or trends of suspicious bruising of residents, unexplained accidents, and injuries of unknown (origin) or other occurrences that may constitute abuse, neglect, or theft. Based on an assessment of the reports,

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the Quality Assurance Committee will further investigate and/or determine whether a change in facility practice is warranted."

In Section IV of the abuse prevention policy, titled Internal Reporting Requirements and Identification of Allegations, employees "are required to immediately report any occurrences of potential/alleged mistreatment they observe, hear about, or suspect to a supervisor or the administrator."

The policy also requires the "administrator or designee to initiate an investigation which includes interviews if appropriate with the victim's roommate, with employees to determine if they have ever witnessed other incidents of mistreatment involving the accused individual." The investigation should also include a "review of all circumstances surrounding the incident."

Interviews with E1 confirmed that the facility did not implement their policies to prevent abuse by not having a mechanism in place to ensure all incident reports are reviewed in a timely manner, that all allegations of abuse and peer to peer aggression are reported to the administrator and the Illinois Department of Public Health, that all allegations of abuse and peer to peer aggression are investigated and assessed for patterns and trends, and that corrective action to prevent further potential abuse is taken.

(A)