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F 490	Continued From page 25	F 490		
F9999	. FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.615e) 300.615f) 300.1210a 300.1210b)6) 300.1220b)3) 300.3240a) 300.3240b) 300.3240d) 300.3240f) Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological	F9999		

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F9999	Continued From page 26 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. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect	F9999		

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F9999	Continued From page 27 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) 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 requirements are not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide a safe living environment, free from sexual assault, for one resident (R2). This failure resulted in R2 being scared and fearful of R1 raping her. R1 was an identified offender. Findings include: R2's Nurses Notes, dated 12/5/09, at 1:30 PM,	F9999		

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F9999	Continued From page 28 reported, "This resident (R2) reported to this nurse another resident (R1) entered her room and lifted up her skirt. When she yelled he left." The note indicated the Director of Nurses and the Administrator were notified of the incident. On 12/23/09 at 8:35 AM, R2 was interviewed in her room. R2 was alert, oriented to person, place, and time. R2 was able to answer all questions without hesitation or confusion, and able to recall the incident. R2 stated R1, "came into my room, shut the door behind him, scared me to death." R2 stated she was already afraid of R1, that he had "ran after me and lifted my dress, so I was already scared. I'm afraid of him...a couple days later, he came in my room. He grabbed me by the shoulders. I thought he was going to rape me. He told me to just lay down. He tried to pull up my skirts. I screamed 'help, help' but no one could hear me with the door shut. He finally left the room and I told the nurse right after he left.....She told me, 'If it happens again, just scream or put on your light.' I don't know what happened to him. I'm just glad he's gone... I'm proud he didn't rape me...." On 12/30/09, at 9:40 AM, R2 confirmed the above statement. R2 noted a few days prior to the incident, R1 had attempted to pull her skirt up while she was walking out of the common-use bathroom. R2 was asked, "What happened the day of the incident?" R2 verbally responded, "He came in and shut the door behind him. He walked over to me and grabbed my shoulders and started to lift my dress. I started to scream. No one could hear me. He let go and told me to lay down on the bed and left. He was the ugliest man I ever saw. He scared me to death. I thought he was going to rape me."	F9999		

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R2's current Minimum Data Set (MDS) assessed R2 as having some short-term memory problems, no long-term memory problems and independent for cognitive decision-making skills, able to make consistent, reasonable decisions.

R1 was admitted to the facility from another nursing home on 11/25/09. He was brought to the facility by his parole office. He was placed in Room 321, next to Room 320, where R2 resided.

R1's Nurses Notes, dated 12/5/09, at 1:30 PM, reported, "Another resident (R2) reported to this nurse this resident (R1) entered into her room & pulled up her skirt while she was laying on her bed. She called out et (and) this resident (R1) left her room. This resident (R1) told this nurse he did not enter her (R2's) room but stood in the doorway asking her to go to TV room. When she (R2) yelled he (R1) went back to his room."

R1' s physician's order sheet, dated November 2009, indicated he had the following partial diagnoses: History of Alcohol Abuse, History of Cocaine Dependency and Antisocial Personality Disorder, and Hepatitis C. Antisocial personality disorder is defined by the American Psychiatric Associations Diagnostic and Statistical Manual as " ...a pervasive pattern of disregard for, and violation of, the rights of others that begins in childhood or early adolescence and continued into adulthood. "

R1 was admitted to the facility with documents from the U.S. Medical Center for Federal Prisoners Springfield, Missouri. The psychology consultation was conducted and written by Z1, Board Certified Neuropsychologist/Forensic

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Psychologist. The consultation, dated 6/29/09, was completed due to a referral for potential release from prison 10/7/09. Z1 indicated in the Clinical Formulation Section of the consultation: "His history includes significant antisocial conduct that started at an early age and continued into adulthood. It appears he has developed a maladaptive personality style comprised of irresponsible and antisocial behavior consistent with antisocial personality disorder." Z1 documented in The Recommendation Section of the consultation: "Without his cooperation with psychological and neurocognitive testing, it is virtually impossible to provide meaningful recommendations. Providers need to be aware that (R1) feigns illness to manipulate care givers and custodial staff. He is ambulatory, but has significant bilateral gain ataxia (incoordination). It is unclear how much of his memory, judgment, and planning may have been affected by the past stroke. Likely, those functions were not affected greatly. Under any living arrangement, he will likely continue to present a management problem given his maladaptive personality style. He has no major mental illness, otherwise, that requires psychiatric interventions. " In addition, the report indicated: "He inappropriately attempted to obtain sexual gratification on several occasions while in the facility by entering the rooms of female peers."

R1 was admitted to the facility on 11/25/09. R1's criminal background check was not obtained until 12/7/09. The criminal background check from Illinois State Police documented R1 had felony convictions and was released with supervision.

E1, Administrator, was interviewed on 12/23/09. E1 had filled out the Department of Public

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Health's Identified Offender Reporting Form. On the form, R1 is identified as "Low Risk." E1 was asked where he received the information that R1 was "Low risk". E1 stated he communicated with R1's parole officer, who was present during R1's admission. E1 stated the parole officer did not indicat that R1 "posed a danger," and that R1's criminal charges were related to theft and burglary, so he assumed R1 was "Low Risk."

The Illinois Department of Public Health Identified Offender System for R1 documented R1 was screened for Risk Analysis on 11/23/09 and the Risk Analysis was received on 12/1/09. Security recommendation: High Risk.

E1 stated all residents are screened using the Department of Justice (DOJ) National Sex Offender Public Website. There is no date on the DOJ website check. E1 stated he was unaware the Illinois State Police and Department of Corrections Websites were to be checked at the time of admission.

R1's Admission Care Plan, dated 11/25/09, indicated he was independent with ambulation, and was at risk for exiting the facility. The care plan did not address R1 as an identified offender. R1's care plan was not updated after his incident with R2 to address R1's sexually inappropriate behavior. The care plan did not document any new progressive interventions for staff to utilize to address R1's sexually inappropriate behavior. On 12/30/09, at 12:00 PM, E9, Minimum Data Set/Care Plan Coordinator, confirmed she was aware of the incident between R1 and R2, and did not update R1's care plan to address his sexually inappropriate behavior.

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F9999	Continued From page 32 On 12/23/09, at 11:40 AM, E4, Certified Nurse's Aide (CNA), noted on 12/5/09 she went into R2's room to lay down R2's roommate. E4 noted R2 was "worked up and scared" and that is why E4 asked R2 how she was doing. E4 indicated R2 responded and said the man in the room next to her (R2) came into the room and scared her. E4 indicated R2 said this man grabbed her while she was on the bed. E4 indicated R2 had already reported this incident to the nurse, E5. E4, CNA, noted the R1 was placed on 15 minute checks after the incident occurred. On 12/30/09, at 10:45 AM, E4 confirmed her statement. E4 indicated R2 was aware of what was going on around her (R2). E4 noted: "I think (R2) could keep a straight story. I told the nurse when (R2) told me." On 12/30/09, at 2:15 PM, E5, Registered Nurse, indicated she was the nurse on duty when the incident occurred between R1 and R2. E5 noted she met R2 in the hallway. She questioned R2 regarding how she was doing. E5 indicated R2 told her she was upset and "that guy came into my room, pulled up my skirt and I yelled." E5 indicated R2 was visibly very upset shaking and wringing her hands while accounting the incident. E5 noted she immediately called E2, Director of Nurse's, and reported the incident. R1 was placed on five minute checks. E5 indicated she spoke with R1 regarding the incident. E5 noted R1 noted he went into R2 ' s doorway and asked her to got to the T.V. room and then left. E5 indicated R2 had no previous behaviors of making false allegations against other residents. E5 indicated "(R2) was quiet. Keeps to herself?" With regards to R1's behavior, E5 responded: "His history was a concern to me. He didn't mix with the elderly. I was aware he had been	F9999		

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incarcerated." E5 indicated she was upset about the situation. She reported the incident to the on-coming shift nurse, E6. E5 indicated she worked the next day, on 12/6/09, and R1 remained in the room next to R2.

On 12/30/09, at 2:53 PM, E7 and E8, Certified Nurse's Aides (CNAs), noted they were not aware of any specific behaviors for which they should have been monitoring with regards to R1. When asked if R1 had displayed any inappropriate behaviors towards the female residents, both indicated R1 was having a sexual relationship with R4.

On 12/30/09, at 3:00 PM, E6, Licensed Practical Nurse (LPN), indicated she was notified by E5 of the incident which occurred between R1 and R2. E6 indicated: "We were keeping an eye on (R1). We were doing our checks. He (R1) had a very loud voice. He made inappropriate comments, not really towards staff, just around staff." E6 was questioned if R1 remained in his room, next to R2's room, the day of the incident. E6 responded: "Yes. I'm not sure when he moved to Room 118. Maybe the next day or the next." E6 was questioned regarding whether R1 was having a sexual relationship with R4. E6 responded by rolling her eyes and noting: "Well, yes, I think they are. I've caught them in each others room. I've heard they are having sex but have never seen them."

E3, Social Services Director, was interviewed on 12/23/09. E3 stated she was informed of the incident on 12/7/09. E3 stated the incident happened on a weekend, Saturday, 12/5/09. E3 stated that when she became aware of the incident on 12/7/09, she moved R1 from the room

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next to R2 to a room on the other end of the building. E3 stated R1 was discharged on 12/9/09, transported to Springfield and released to the parole officer in Springfield. E3 stated that a parole office accompanied R2 during admission to the facility on 11/25/09. E3 stated, "The probation officer (PO) was aware of all the information on admission. I called the PO after the incident on 12/5/09 and told her we couldn't meet his (R1) needs. He posed a risk to other residents." E3 verified R1 was not discharged until 12/9/09.

On 12/30/09, at 12:37 PM, Z2, R1's Parole Office, indicated R1 had been at another facility prior to his admission to this facility. She indicated R1 had been discharged from the other facility due to not following the other facility's rules. When asked why R1 was discharged from this facility, Z2 responded: "We were told he was acting inappropriately towards other residents and not respecting the privacy of other residents. We were told he lifted the gown of another female resident. "

E2, Director of Nursing, was interviewed on 12/23/09. E2 stated she was notified of the incident on 12/5/09. E2 stated she was not aware that this was an allegation of abuse. E2 stated, "I've only been working here since July. I'm really not familiar with the Abuse Policy." E2 verified that the allegation was not reported to IDPH. E2 was shown R1's Nurses Notes. There are no Nurses Notes in R1's chart from 12/5/09 until 12/8/09. There is no documentation regarding R1's behavior related to the incident of 12/5/09. On 12/9/09, Nurses Notes stated he was discharged from the facility. There is no clear documentation how the facility kept R2 and

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F9999	Continued From page 35 other residents safe from R1 until discharge. E2 stated R1 had been put on 15 minute checks, but the observation papers only document R1's location, not behavior. On 12/30/09, at 9:15 AM, E2 was again interviewed regarding the incident between R1 and R2. E2 was asked, " Did the facility report this allegation to the Department?" E2 responded, "No, we didn ' t find anything. We had conflicting stories." E2 indicated R1 was placed on five minute checks and was immediately moved to Room 118. E2 noted she told "them" to move R1 that day. E2 confirmed the police had not been notified due to failure to validate the allegation of abuse. On 12/31/09, at 1:00 PM, E2 confirmed R1 had not been moved to another room until 12/7/09, two days after the incident occurred. On 12/30/09, at 4:30 PM, E2's response to the question regarding whether R1 and R4 were having a sexual relationship was, "Oh, yes." When asked how she knew this to be fact, E2 responded, "They were in her room all the time. Staff was finding condoms on her (R4) floor and in the trash can." R1's 15 minute tracking sheets, from 12/5/09 through 12/9/09, indicated R1 was either in the dining room, smoking on the patio, in his room, in the hallways ambulating, or in the television room. These tracking sheets did not identify R1 was in R4's room at any time. (A)	F9999		