Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008338	A. BUILDING: ______ B. WING ______	C 12/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM VILLAGE NURSING & REHAB	**1314 ROWELL AVENUE JOLIET, IL 60433**

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S9999	Final Observations	S9999		

Statement of Licensure Violations

300.610a)
300.695a)3)
300.695b)3)
300.695c)1)
300.3240a)
300.3240b)
300.3240e)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.695 Contacting Local Law Enforcement

a) For the purpose of this Section, the following definitions shall apply:
3) Sexual abuse - sexual penetration, intentional sexual touching or fondling, or sexual exploitation (i.e., use of an individual for another person's sexual gratification, arousal, advantage, or profit).

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S9999	Continued From page 1 b) The facility shall immediately contact local law enforcement authorities (e.g., telephoning 911 where available) in the following situations: 3) Sexual abuse of a resident by a staff member, another resident, or a visitor; c) The facility shall develop and implement a policy concerning local law enforcement notification, including: 1) Ensuring the safety of residents in situations requiring local law enforcement notification; Section 300.3240 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) e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act) These Regulations were not met as evidenced	S9999		

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by:

Based on interview and record review facility failed to protect a female Resident (R1) from sexual abuse, by a male staff person (E3 - Certified Nurse Aide - CNA), on 11/22/2013. The facility failed to implement it's abuse policy and procedures to protect the resident from possible further abuse and immediately report the abuse to facility administrator and local law enforcement.

These applies to 1 of 3 sampled residents (R1), reviewed for abuse.

The Findings include;

R1's 11/22/2013 facility incident investigation report includes:
An allegation of Sexual Abuse. On 11/22/13 at 4:45AM, E2 (nurse aide), walked into R1's room and witnessed E3 (male nurse aide), kneeling behind R1, as she was lying in bed. E2 stated "It appeared to her, that {E3} was having sex with {R1}." E2 documented, R1 was undressed waist down, lying on her side and facing the wall. E3 was kneeling on R1's bed, behind R1 with his hand on R1's right leg and moving his hips back and forth. E3 backed away from R1 when E2 entered the room.

R1's medical records includes:
R1 is a 19 year old female with a recent Traumatic Brain Injury.
9/05/13 Admission Assessment include, alert and oriented times one.
Current care plan and 10/16/13 minimum data set

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assessment (MDS), document R1 requires extensive to total assistance with one staff for activities of daily living (bed mobility, transfers, ambulation, eating, hygiene, bathing and toileting), is frequently incontinent of bowel and bladder, has decreased range of motion to all extremities, muscle spasticity, left foot drop and impaired cognition and short term memory.

During 12/05/13, 11:55AM telephone interview, E23 (R1's speech / Language pathologist), stated that R1 has diminished short term memory. E23 said R1 could not remember what she had eaten an hour or two after a meal. R1 can express pain and discomfort, as it is occurring but may have problem remembering pain she had earlier the same day. R1's recall is better for repetitive, frequent or daily events, like therapy. E23 also stated that R1's vocabulary is at a 2nd or 3rd grade level.

E2's 11/22/13 written statement and 11/26/13, 9:44AM individual interview includes:
On 11/22/13 at 4:45AM, after witnessing E3 kneeling behind R1, "pumping back and forth on R1's buttock", E2 stated "I didn't say anything because my heart was pounding. I left {R1's} room and took care of another resident" E2 said after repositioning another resident in bed, she passed E3 in the hallway, E3 was exiting R1's room and E3 appeared to be sweaty at that time. E2 documented feeling sick , like she was going to pass out from what she observed in R1's room. After answering other residents call lights, she approached E7 (nurse), and told her she felt sick but still did not notify E7 of her observation. E2 continued to answer resident call lights. Eventually, E2 reported what she saw to E7.
E2 stated, after notifying E7 of what she saw, E2 continued to answer call lights and observed E3

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back in R1's room with the resident. E2 said she again approached E7, whom was passing medications and told her that E3 was back inside R1's room with the resident. E7 then went into R1's room to give R1 her medications, E3 was still with R1. E7 left R1's room, leaving E3 and R1 alone in the room.
E2 said, at 5:30AM, she observed E3 sitting in a chair, in the television room. E2 approached E3 and asked what he was doing with R1. E3 responded saying he was exercising R1, as he has done before. E2 replied to E3, saying "Exercising residents is not their job, it's therapies job." E2 stated "I told {E3}, I saw you, I saw you, I saw you." E3 did not verbally respond, he was blushing and just starring at E2.

E7's 11/22/13 written statement and 11/26/13, 10:14AM individual interview includes:
On 11/22/13 between 4:45AM and 5:00AM, E2 approached E7, complaining of not feeling well. E2 then went to answer resident call lights. After answering resident call lights, E2 started pacing in front of E7's medication cart. E7 asked E2 what was wrong and E2 said she observed E3 behind R1 with his "penis" out. E7 then prepared R1's medication and took them to R1's room. E7 observed R1 fully dressed and sitting on the edge of her bed and E3 in the room with R1. E7 then stepped out of R1's room, leaving E3 alone with R1 and continued to pass medications to other residents.

E5's (assistant director of nursing)11/22/13 written statement and 11/22/13, 5:35PM interview includes:
On 11/22/13, at 5:33AM, E5 called E7 in response to a 5:13AM text received, "to call as soon as possible." E7 stated that E2 observed E3 sexually abusing R1. E5 documented; after he

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was notified, he called E6 (facility security guard), and directed him to remove E3 from the 2nd floor and call the police. E6 was unable to leave the front door in the lobby at this time, due to change of shift. E5 then directed E7 to bring E3 downstairs to E6 in the first floor lobby and call the police. E5 then notified E1 (Administrator), E10 (DON) and E19 (ADON) of the abuse allegation and arrived to the facility between 6:15AM and 6:20AM. Upon arrival to facility, E5 witnessed E3 being hand cuffed by police and R1 was being picked up by the ambulance.

E6's 11/22/13 written statement and 11/26/13, 11:43AM telephone interview includes:
On 11/22/13 at 5:55AM, E5 called and directed him bring E3 to the front lobby and not let E3 out of his sight. E6 stated he was unable to leave the lobby at that time due to being in the middle of a shift change. During shift changes the security guard must be present to let staff in and out of the front lobby door. E6 said after E7 brought E3 downstairs to the lobby, E6 then called the police.

During an 11/27/13, 9:34AM interview, Z1 (police detective), stated, on 11/22/13 at 6:03AM, police department received the call from facility reporting a possible sexual assault of a resident.

E3's 11/22/13 time card documents, E3 worked the entire shift 10:00PM through 6:00AM.
E3's time card is punched in and out at the 2nd floor time clock. E3 was not removed from the 2nd floor until after 6:00AM. On 11/22/13, E3 was allowed continued direct, unwitnessed contact with R1, after the above 4:45AM, witnessed incident, until 6:00AM (end of his shift). E3 had cleaned, dressed and repositioned R1 by himself between 4:45AM and 5:13AM.

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Facilities Abuse Policy and Procedure includes :
VI. Protection of Residents = Employees of this facility who have been accused of abuse, neglect or mistreatment will be removed from resident contact immediately. Employees accused of possible abuse, neglect or misappropriation of property shall not complete the shift as a direct care provider to residents.
This policy does not include verbiage stating staff are to immediately report abuse allegations and suspicions of crimes to administration and local law enforcement.

Facility Administrator (E1), notified of incident 11/22/2013 at 5:40AM, by E5. Police notified at 6:03AM. and R1 sent to the hospital for an emergency room evaluation after 6:15AM.

R1's 11/22/13 Emergency Room (ER), reports includes;
11/22/13 admitted to ER at 7:02AM for evaluation after a sexual assault at nursing home by a male staff member. R1 unable to provide any history due to mental / cognitive deficits.
Z3 (ER physician), physical exam report documents :
physical exam = no acute distress, area of redness on the anterior left thigh, area of linear excoriation on the proximal medial aspect of both thighs.
Genitourinary exam includes evidence of a superficial abrasion / tear at the superior portion of the introitus. No bleeding. There is an area of erythema at approximately 4:00 o'clock at the introitus / labia. Speculum exam reveals mucoid liquid in the vaginal vault. The Cervix is erythematous with moderate ectropan.
An assault kit was completed and provided to police officer.

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S9999	Continued From page 7 During 12/05/13, 1:10PM, telephone interview, Z4 (Gynecologist), stated, R1 evaluated 11/27/13 and observed with an orange colored vaginal discharge. Z4 stated R1 was provided treatment for a bacterial infection. Z4 said R1's 11/22/13 ER report reviewed and the erythema and ectropan of the cervix and superficial abrasion / tear at 4:00 o'clock on the superior portion of the introitus, are signs of possible sexual abuse. During 12/04/13, 11:05AM telephone interview, Z2 (facility medical director / R1's primary physician), stated that R1's abrasion on the introitus is from some type of traumatic injury. Z2 also stated if a staff person becomes aware of an abuse, they should immediately notify their supervisor and the police. (A)	S9999		