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	IL6006365	A. BUILDING: _____ B. WING _____	C 09/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOCKTON HEALTHCARE & REHAB	501 EAST FRONT STREET, PO BOX #38 STOCKTON, IL 61085

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S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)3) 300.1210d)6) 300.1220b)3) 300.3240a) 300.3240b) 300.3240f) 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 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing	S9999		

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S9999	Continued From page 1 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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,	S9999		

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S9999	Continued From page 2 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 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) 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:	S9999		

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Based on Interview and Record Review the facility failed to follow its policies and procedures that direct staff to immediately report allegations of abuse and investigate allegations of abuse. The facility staff witnessed R1 gagging R3 with his penis on 8/24/14 but did not report it to the Abuse Coordinator. Facility staff witnessed R1 making R3 play with his penis and putting his penis in her mouth on 8/25/14 and did not report it to the Abuse Coordinator. The facility staff witnessed R1 putting his penis in another resident's face on 8/26/14 which was not immediately reported to the Abuse Coordinator. These failures resulted in two female residents being subjected to sexual abuse.

This applies to 2 of 3 residents (R2 & R3) reviewed for sexual abuse in the sample of three.

The finding includes:

The Nurses Notes dated 7/31/14 for R1 showed, "7/31/14 at 4:00am - R1 has been walking through the facility without clothes approximately 5 times this shift; 3:30pm - R1 found ambulating naked in the hallway again with his walker. Certified Nursing Assistants (CNA) intervened and covered R1 with a blanket and asked him what he is doing? R1 stated, "Don't you like what you see?"; 3:45pm - R1 again took all of his clothes off and was found wandering the hallway naked. CNA took him back to his room and he began making inappropriate comments and sexual advances towards CNA. CNA told R1 that he needs to put his clothes back on and he stated, "Let's make a deal." The CNA stated, "The deal is you need to put your clothes back on." R1 stated, "I will do that if I get to touch your

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breast." R1 then growled at CNA in a sexual manner. CNA also now reports that R1 was found in this same resident's room with one of her knick - nacks in his hand. I spoke with R1 about his inappropriate behavior but he laughs and seems to think this is funny. All behaviors reported to SSD and will continue to have staff continue to write incident reports for behaviors."

The Nurses Notes dated 8/2/14 for R1 showed, "3:15pm - R1 found naked near his doorway in his room. CNA asked R1 if she could help him get dressed and R1 stated, "No, I want to expose myself to all of you girls." CNA told R1 that his behavior is not appropriate and he stated, "Don't you want to look at my nice prick?" CNA left room to get another CNA to return to room with her. They then told R1 that this behavior was not appropriate and he cannot be talking like that to staff. R1 stated, "Well don't you want to look at it?"

On 8/26/14 at 1:45pm E2 (Director of Nurses - DON) read the Nurses Notes dated 7/31/14 and 8/2/14 for R1 and stated, "They are supposed to be filing out an Incident report with each incident. I didn't know about this incident (8/2/14)." E2 stated she did not know about R1 masturbating in front of another resident's doorway (7/31/14).

On 8/27/14 at 8:20am, E7 (Certified Nursing Assistant - CNA) stated, "On 8/24/14 I heard a noise and went to R1 & R3's room. I turned the light on and asked if I could help. R3 was on her back in her bed and R1 had his penis in her mouth. R3 was gagging and trying to fight R1 off. R3 was upset. R1 stood up, zipped up his pants and sat in a chair. R1 acted like he knew what he was doing that morning. I told E9 (Licensed Practical Nurse - LPN) and she said to redirect

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S9999	Continued From page 5 R1 away from R3." On 8/26/14 at 3:50pm, E4 (CNA) stated, "R1 was up walking around all night (8/25/14). R1 kept taking his penis out of his pants and we were redirecting him to cover up. It was around 3:00am, and he was by the A hall nurses station with his pants down and penis about 3 inches from R2's mouth. R1 was saying, "Come on." R1 does this to his wife (R3) all of the time. I don't think she likes it. E7 told me she heard choking noises one morning and went into R1 & R3's room. R1 had his penis in R3's mouth. E8 (CNA) saw R1 with his wife and had to stop it; he was making her do it, have oral sex. R1 is pushy with R3. When R3 is at dinner with other ladies, she smiles and talks. When R1 is around, R3 looks sad and just sits there." The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/7/14 for R3 shows impairment of short term memory, long term memory and cognition. On 8/26/14 at 11:50am, E1 (Administrator) stated, "This took place between 2:30am and 3:00am this morning (8/26/14). I did not receive any phone calls last night. I am the Abuse Coordinator and I should have been notified. I got a call after E3 (Social Service Director - SSD) was informed after 7:00am today. R1 reportedly had been standing in front of R2 with his penis in her face. R2 was sitting in a wheelchair. It is not unusual for R3 to be up in the middle of the night. This was witnessed by E4 (CNA). E4 reported it to E5 (LPN) who did not think it was abuse. R1 has walked down the hall one time without his clothes on. R1's wife (R3) is a resident here and she is very confused. R1 and R3 are in the same room together."	S9999		

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On 8/26/14 at 12:30pm, E3 (Social Service Director - SSD) stated, "I walked in today and me and E6 (Registered Nurse - RN) were discussing R1 and R3's behavior. E7 (CNA) came up and said that E4 told her this morning that R1 put his penis in R2's mouth. I asked E7 if anyone else was notified and she said she didn't know. E6 and I decided to contact E2 (Director of nursing - DON) who said she didn't know anything about it. I hung up and said I was contacting the state (Illinois Department of Public Health - IDPH). I called the hotline. E5 said it did not happen and that she didn't see it so that is why she did not call anyone."

On 8/26/14 at 12:49pm, E2 (Director of Nursing - DON) stated, "I was called at 7:20am today. E4 said R1 stuck his penis in R2's mouth. I came in to the facility. E1 was already here when I got here. E5 (LPN) should have notified us when this happened. She knows she is to contact us."

The facility's Abuse Policy and Procedure (8/2011) showed, "Definition of Abuse: Sexual assault, or raping a resident or forcing a resident to engage in other sexual acts; Sexual Abuse includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault; During orientation of new employees as well as at least annually, the facility conducts training on sensitivity to residents needs, including the definition of abuse, neglect and misappropriation of resident property, as well as abuse reporting and investigation obligations."

The facility's Reporting on Abuse Allegation "(7/2014) showed, "Any allegation of abuse, neglect or theft from a resident will result in the following: The one who witnesses or has any

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knowledge of an act or suspected act of abuse shall notify the Administrator, Illinois Department of Public Health (IDPH), resident's family, and physician, if applicable, will be informed immediately; All reported acts or suspected acts of abuse shall be immediately and thoroughly investigated. The one who suspects a crime occurring that involves serious bodily injury must report that suspicion to the police and IDPH immediately."

The facility's "Procedure on Abuse Allegation" dated 7/2007 showed, "The one who witnesses or has any knowledge of an act or suspected act of abuse shall notify the administrator, Illinois Department of Public health, resident's family and physician, If applicable, will be informed immediately. All reported acts or suspected acts of abuse shall be immediately and thoroughly investigated."

The Incident Reports for R1 dated 7/31/14 showed, "At 2:20pm - R1 walked into hallway with only socks and shoes on. I walked him back to his room and told him we don't walk around like this. R1 stated, "Don't you like what you see?" I told him we don't do this, let's get dressed. As I was dressing R1 he was fondling my breast. I was fixing his pants bent over and R1 started feeling my butt. I told him we don't touch workers or anyone. I was fixing R1' s shirts and he started to jack off. R1 said, "Don't you want to help me?" I told him we don't act like this."; at 3:30pm - R1 was naked in the hallway and I took him to a room to get dressed and he stated he can touch my breasts. R1 licked his lips groaning at me saying, "That looks nice." while staring at my chest. "

The Incident Reports for R1 dated 8/5/14

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showed, "3:00pm - R1 was walking down the hall heading towards the desk with his genitals out so others could see his genitals; 3:15pm R1 was standing by A1 (R2's room) where visitors were and his private parts were hanging outside of his pants."

The Incident Reports for R1 showed, "8/6/14 - R1 was standing at the door of his room pulling out his penis. After supper R1 was being very mean to R3; 8/8/14 - R1 was standing in the hallway with his genitals out. I told R1 to zip his clothes. I told R1 that he can't expose himself. R1 repeated it three times. R1 waved me off with his hand when I asked him if he understood. He then zipped his clothes and returned into his room; 8/9/14 -R3 was sitting next to R1, after breakfast, in the living room. R1 told R3, "Oh just be quiet. Go, get out of here. Go get up, I dare you. I hope you fall down."; 8/25/14 - R1 was making R3 play with him in the living room and putting his penis in her mouth."

The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/7/14 for R1 showed a Brief Interview for Mental Status (BIMS) score of 11/15 (Moderate Cognitive Impairment).

On 8/27/14 at 4:55pm, Z1 (R3's Power of Attorney - POA) stated, "I have been to the nursing home three times today. They moved R3 and placed her with another resident. R3 will be safe now. I don't want R3 back in a room with R1. The facility told me R1 was getting more aggressive with his sexual behaviors. About 10 months to 1 year ago R3's dementia got worse so I hired caregivers to care for her 8 hours a day. I felt R1 was declining too but he said he didn't need any help and it's not my decision to make.

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S9999	Continued From page 9 R1's daughter is his POA. R1 and R3 have been married for 40 years. R1 was never controlling until R3's dementia got worse. R1 started with this behavior over the last 10 -12 months since R3 got worse. R1 was pulling his pants down and exposing himself to the caregivers. When R1's behaviors increased I made the decision to have R3 moved here. R1's daughter agreed to have him moved here. R3's dementia is so bad that she doesn't even know who R1 is anymore. I didn't know R1 was having physical contact with R3 or gagging her." R1's Care Plan dated 7/21/14 showed, "R1 exposes himself in public places; Goal - Lessen public exposure; Interventions - Verbal redirection; Educate on sexual exposure; Invite resident to activities to help limit down time; Provide room for him and his spouse to be intimate." (A)	S9999		

Imposed Plan of Correction

Stockton Healthcare & Rehab

FACILITY RESPONSE

CORRECTIVE MEASURE TAKEN:

1. **ALL STAFF WERE IN-SERVICED ON 8/27/14 ON FACILITY ABUSE POLICIES BEFORE BEING ALLOWED TO WORK. THOSE IN-SERVICES INCLUDED:**
   - **WHAT CONSTITUTES ABUSE**
   - **THE DIFFERENT TYPES OF ABUSE**
   - **WHO IS AT RISK FOR ABUSE**
   - **WHAT TO DO IF ABUSE IS SUSPECTED AND/OR WITNESSED**
   - **WHEN TO REPORT (IMMEDEDIATELY)**
   - **WHO TO REPORT ABUSE TO**

MEASURES FACILITY WILL TAKE TO ENSURE PROBLEM DOES NOT RE-OCCUR ARE:

1. **ALL STAFF RE-INSERVICED ON 9-18-14 AND 9-19-14 ON ABUSE POLICIES. THOSE IN-SERVICES INCLUDED:**
   - **WHAT CONSTITUTES ABUSE**
   - **THE DIFFERENT TYPES OF ABUSE**
   - **WHO IS AT RISK FOR ABUSE**
   - **WHAT TO DO IF ABUSE IS SUSPECTED AND OR WITNESSED**
   - **WHEN TO REPORT**
   - **WHO TO REPORT ABUSE TO**
   - **SUSPICION OF A CRIME AND WHAT TO DO**

2. ALL NEW EMPLOYEES WILL BE TRAINED FACE TO FACE BY ADMINISTRATOR BEFORE THEY WORK ON THE FLOOR.
3. ZERO TOLERANCE POLICY REVIEWED WITH ALL STAFF ON 9/18/14 AND 9/19/14.

4. IN-SERVICE WILL BE GIVEN BY LYNDA MARKUT LSW ON 10-1-2014 AT STOCKTEN HEALTHCARE. THE SUBJECT WILL BE: <u>INTIMACY AND SEXUALITY IN LONG TERM CARE FACILITIES.</u>
   - JUDGING THE ABILITY OF RESIDENTS TO PARTICIPATE INTIMATE AND SEXUAL RELATIONSHIPS; EMPHASIZING NO MEANS NO!
5. QA MANAGER OR DESIGNEE WILL CONDUCT QA AUDITS OF 3 RANDOM STAFF FOR 10 DAYS TO ENSURE STAFF ARE AWARE OF POLICIES.
6. QA WILL CONTINUE TO MONITOR AND DECIDE FUTURE AUDTIS.