

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145371	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 7/22/04
NAME OF PROVIDER OR SUPPLIER ASTA CARE CENTER OF BLOOMINGTN			STREET ADDRESS, CITY, STATE, ZIP CODE 1509 NORTH CALHOUN STREET BLOOMINGTON, IL 61701		
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F9999	<p>FINAL OBSERVATIONS</p> <p>Surveyor: 13108 STATE FINDINGS</p> <p>The following STATE VIOLATIONS CITED in regards to this survey:</p> <p>300.610 a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated there under. These written</p>	F9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F9999	Continued From page 54 policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. 300.690 a) 1) 300.690 a) 2) The facility shall notify the Department of Public Health of any incident or accident which has, or is likely to have, a significant effect on the health, safety or welfare of a resident or residents. Incidents and accidents requiring the services of a physician, hospital, police or fire department, coroner, or other service provider on an emergency basis shall be reported to the Department. (1) Notification shall be made by a phone call to the Regional Office within 24 hours of each serious incident or accident. If the facility is unable to contact the Regional Office, notification shall be made by a phone call to the Department's toll-free complaint registry number. (2) A narrative summary of each serious accident or incident occurrence shall be sent to the Department within seven (7) days of the occurrence. 300.690 b) A descriptive summary of each incident or accident shall be recorded in the progress notes or nurse's notes for each resident involved. 300.690 c) The facility shall maintain a file of all written reports of serious incidents or accidents involving residents. 300.1010 h) Facility staff shall notify the resident's physician of	F9999			

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F9999	Continued From page 55 any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 300.1210 a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Personal Care, as defined in section 300.330, is assistance with meals, dressing, movement, bathing or other personal needs or maintenance, or general supervision and oversight of the physical and mental well-being of an individual who is incapable of maintaining a private, independent residence or who is incapable of managing his person, whether or not a guardian has been appointed for such individual (Section 1-120 of the Act). 300.1210 b) 3) 300.1210 b) 6) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: Objective observations of changes in a resident's	F9999		

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F9999	<p>Continued From page 56</p> <p>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.</p> <p>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.</p> <p>300.3240 a) 300.3240 b) 300.3240 c) 300.3240 d) 300.3240 f)</p> <p>An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator.</p> <p>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.</p> <p>A facility administrator who becomes aware of abuse or neglect of a resident shall also report the matter to the Department.</p> <p>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</p>	F9999		

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F9999	Continued From page 57 placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. The facility failed to ensure that these regulations were followed by: (1) Based on record review and interview the facility: (a) Failed to thoroughly investigate an allegation of R6 sexually fondling R11. (b) Facility failed to thoroughly investigate allegations regarding R6's inappropriate sexual behavior towards R7, R8 & R10. (c) Facility staff failed to immediately report to the Administrator an allegation by R7 that R6 displayed inappropriate sexual behavior towards her. (d) Facility failed to notify the Department of Public Health about 4 of 5 known allegations of R6 displaying sexually inappropriate behaviors. (2) Based on record review and interview the facility failed to notify the receiving facility that R6 had a history of resident-to-resident sexual fondling and inappropriate sexual behaviors. (3) Based observation, interview and record review, the facility failed to assess, notify the physician, identify and implement interventions to provide supervision for R6 related to the incidents of sexually inappropriate behaviors. (4) The facility administration failed to act upon concerns voiced by members of the facility's management team that the placement of R6 in the facility was not appropriate. The failure of administration to act on the concerns voiced about the inappropriate placement of R6 in the facility, resulted in repeated inappropriate resident-to-resident sexual behaviors. (5) The facility administration failed to ensure	F9999		

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F9999	<p>Continued From page 58</p> <p>that facility staff documented R6's inappropriate sexual behaviors by instructing the staff not to document the behaviors.</p> <p>(6) Based on observation, interview and record review the facility neglected to develop and implement policies and procedures to ensure a thorough investigation, notification of the physician and identifying interventions addressing resident-to-resident behaviors such as R6's inappropriate sexual fondling of female residents.</p> <p>(7) Based on observation, record review and interview the facility failed to supervise R6, a delusional resident identified at risk for elopement, resulting in R6 leaving the facility and walking, unescorted, to a location 1.8 miles from the facility. The facility failed to communicate to staff that R6 was identified as an elopement risk, that he was wearing a electronic monitoring device and was to only be outside with supervision. R6 left the facility without staffs knowledge and was missing for 2½ hours.</p> <p>Findings include:</p> <p>(1) Background information on R6 The Physician Order Sheet (POS) dated 6/1/04 to 6/30/04 states that R6 has diagnoses of Paranoid Schizophrenia, Diabetes and Chronic Obstructive Lung Disease. The physician orders include: "Resident is not to leave the building alone, without supervision; Resident may leave building only with responsible party and [Electronic monitoring device] on for elopement risk."</p> <p>The comprehensive resident assessment dated 3/30/04 states that R6 has no long or short-term memory problems, has impaired decision-making ability, has delusions and is independent with</p>	F9999		

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F9999	<p>Continued From page 59</p> <p>transfers and ambulation. The facility Elopement Risk Assessment Tool, dated 6/7/04, identifies R6 as at risk for elopement.</p> <p>R6's care plan, dated as reviewed on 4/6/04, has an entry dated 2/20/04 stating, "Monitor [R6] for inappropriate behavior with other female residents", with interventions listed as, "Check [R6] whereabouts frequently; Place [R6] near nurses station if [up] at [night] to monitor." There are no other interventions listed on the care plan identifying how facility staff should supervise R6 to prevent a reoccurrence of incidents such as the one that occurred on 2/19/04. This care plan also identifies that R6's electronic monitoring device was reapplied on 6/7/04 and has the following additional interventions related to wandering identified: "Supervised smoking; [Electronic monitoring device] check daily; Explain to [R6] he has to have someone with him even to go outside."</p> <p>The nurses' notes, dated 6/23/04, state that Z4 was notified of R6's "[increased] sexual behaviors" and that a physician order to increase the medications (psychotropic) dose was received. The physician order sheet has an order, dated 6/24/04, for Depoprovera 150 mg IM [intramuscular] every 3 months.</p> <p>(2) Incident of Inappropriate Sexual behavior towards R11 on 02/19/04</p> <p>E14, stated in interview on 6/30/04 at 8:10AM, that when she walked into the room she saw both R6 and R11 lying in the bed naked, with R11 lying closest to the wall and R6 lying on the outside of the bed. E14 stated that she witnessed R6</p>	F9999		

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F9999	<p>Continued From page 60</p> <p>"rubbing the shaving cream on her [R11] peri area." E14 stated that R11 was just lying there, not crying, but had a "look of shock on her face, like 'Oh My God'." E14 stated that after she removed R11 from R6's room, R11 kept saying, "Thank you, Thank you, I don't know what he was doing." E14 stated when she washed the shaving cream off of R11's peri area that there was no blood, only shaving cream. E14 stated that she told E18 everything that she saw. E14 was not sure of the date of the incident.</p> <p>The nurses' notes, dated 2/19/04 at 1:30AM and 1:40AM state, "Found [R6] naked sitting on edge of bed with female [R11] naked in bed. [R11] had shaving cream on peri [perineal] area. [R11] removed from room. When asked [R6] why she [R11] had shaving cream on her, he replied, 'Because she was dry'. [R6] out on 300 patio smoking and I asked him why [R11] was in his room. [R6] said, 'I don't know, I turned around and she was there.'" The nurses' notes, dated 2/19/04 at 1:45AM and 2:00AM, state that E23 and E1 were notified of the incident.</p> <p>E18 stated, in interviews conducted on 6/30/04 at 8:40AM, 7/2/04 at 8:35AM and 7/6/04 at 11:30AM, that she was at the nurses' station when the E14 told her what she saw. E18 stated that R6 told her that he put the shaving cream on R11 because she was "dry". E18 stated that she did not witness anything, that by the time she got there R11 was cleaned up and R6 was out smoking. E18 stated that she did not examine R11 following the incident because she was not sure how to examine R11 or what to do and that was why she notified E23 and E1. E18 stated that she "had no evidence that [R6] touched [R11], that nobody told me he</p>	F9999		

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F9999	<p>Continued From page 61</p> <p>touched her." E18 stated that she was told by the CNA that she walked in and found shaving cream on R11. E18 stated that she interviewed R6, but did not interview any other residents or staff. E18 stated that she did not interview R11, as she did not think that she would get an answer from R11 that would make sense. E18 stated, in the interview of 7/6/04, that she did not notify R6's physician after the 2/19/04 incident.</p> <p>E1 stated, in interview on 6/30/04 at 2:30PM, that after the 2/19/04 incident they reported it to the police and sent R11 to the hospital. E1 stated that E18 told her that R6 admitted that he put shaving cream on R11 because 'she was dry' and that was why we sent R11 to the emergency room to be checked. E1 stated that she interviewed E18, and was told by E18 what E14 found, but did not interview E14 or any other staff members or residents. E1 stated that she did not interview R11 because she doesn't make any sense. R6 was moved to another room, across from the nurses' station for better supervision, and R11 was moved to the 400-Hall for increased supervision, as there is a lot of staff activity on the hall. E1 stated in a 2nd interview, on 7/2/04 at 11:45AM, that she thought that R6 had done something to R11, that's why they sent her to the hospital to be evaluated, that she had gotten that information from E18. E1 stated, in a 3rd interview on 7/6/04 at 11:40AM, that after the February incident, she was not aware of R6 having any other inappropriate sexual behaviors until sometime in June.</p> <p>The McLean County Incident Report dated 2/19/04, completed by the police, states under the section titled Summary: "Two residents [R6, R11] were found sleeping together which is against nursing</p>	F9999		

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F9999	<p>Continued From page 63</p> <p>that she only knew "bits and pieces" of what had occurred. E24 denied that she had led Z7 to believe that what happened between R6 and R11 was consensual.</p> <p>The facility investigation includes a letter to the Department of Public Health, dated 2/20/04 and stating that on 2/19/04 at 1:30AM a CNA reported finding R11 in R6's room, naked. R6 was found sitting on the side of the bed, naked. The letter states that when asked why R11 had shaving cream on her peri area, R6 replied, "she was dry", and stated "what is she (R11) doing in my bed." The letter also contains the information that R11 will sometimes wander out of her room without her clothes on, and that R11 was sent to the emergency room to be examined and that the police department was notified of the incident. A copy of the police report of the incident and the nurses' notes complete the facility investigation. There is no other documentation of the facility investigation or documentation of staff or resident interviews.</p> <p>R11 has a physician order sheet for 6/1 to 6/30/04, which states that R11 has a diagnosis of Alzheimer's with confusion and delusions. The psychiatric progress note dated 4/26/04 states that R11 is "confused, rambling speech, wandering behavior, Severe Dementia." The comprehensive resident assessments, dated 2/4/04 and 5/4/04, state that R11 has long and short-term memory problems, impaired decision-making ability, wanders daily and is independent with transfers and ambulation. The care plan dated 5/10/04 states, "[R11] tends to wet bed and take gown off and wanders around room/hall naked", with the following interventions being identified: "Bed alarm</p>	F9999		

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F9999	<p>Continued From page 64</p> <p>applied 2/25/04; Check resident's whereabouts frequently; Place resident near nurses station if [up] at [night] to monitor; Assist resident to BR [bathroom] when incontinent and naked at [night]; Assist with dressing."</p> <p>There is no documentation in R6's nurses' notes that neither R6's psychiatrist nor attending physicians were notified of the incident. E18 stated, in interview on 7/6/04 at 11:30AM that she did not notify R6's physician after the 2/19/04 incident. E21 stated, in interview on 7/6/04 at 1:10PM, that there is nothing documented in the nurses notes or on the POS to indicate that the physician was notified.</p> <p>Z1 stated, in interview on 7/2/04 at 11:55AM, that he just became aware that R6 was having sexual behaviors, when he put him on the medication Depoprovera. Z1 stated that he did not remember the February incident and did not know if it was brought to his attention or not. Z1 stated that R6 has a long history of mental illness and that sexual behaviors are quite common in residents with this diagnosis. Z1 stated that he does not think that R6 knows that he shouldn't be doing that [inappropriate sexual behaviors] in that situation, "not like you or I would." Z1 stated that R6 has "no control over himself at all and is totally irresponsible to take care of himself." The physician order sheet has an order dated 6/24/04 to start the medication Depoprovera, which inhibits sexual behaviors.</p> <p>Z4 stated, in interview on 7/6/04 at 3:05PM, that she was not aware of any incident in February 2004 involving R6 and inappropriate touching of a female resident. Z4 stated that she first became aware of</p>	F9999		

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F9999	<p>Continued From page 65</p> <p>sexual behaviors of R6 last week (6/23) when E2 called her.</p> <p>(3) Incident of Inappropriate Sexual behavior towards R10: R6's nurses' notes, dated 6/12/04 at 5:00PM, state that "[R6] had pushed married peer [R10] into his room. [R6] has the lady [R10] up out of her w/c [wheelchair] walking toward his bed. [R6] has removed [R10's] [personal] alarm and [positioning device]. The ringing alarm, R6 placed in a closed container, the [positioning device] on the floor. [R6] indicated that 'she did it'." Further nurses' notes, dated 6/15/04, state that R6 was moved to another room. There is no documentation of any other interventions being done.</p> <p>E11 stated, in interview on 6/29/04 at 3:55PM, that R10 has a positioning device and a personal alarm. E11 stated that they heard the alarm ringing and were looking for R10, when they found R10 in R6's room. E11 stated that R6 was attempting to lift R10 from the wheelchair to the bed. E11 stated that R10 was by the television, about 3 feet from the bed when she saw her with R6. E11 stated that R10 was fully dressed and when she asked R6 what he was doing R6 replied that he thought she [R10] would want to watch television. E11 stated at that time she put R10 back in the wheelchair. E11 stated that she was unable to find R10's glasses at that time, but about 1 hour later R10's glasses suddenly appeared on top of the medication cart. E11 stated that the personal alarm was found, still alarming, in a isolation container (covered linen container), located in the hall outside of R6's room. E11 stated that she had seen R10 right before the incident, and R10 was in the wheelchair with the positioning device in place</p>	F9999		

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F9999	<p>Continued From page 66</p> <p>with her glasses on. E11 stated that she has never seen R10 remove the positioning device and does not believe that she is able to remove the device. E11 stated that she thought that R6 removed the positioning device from R10, as well as her glasses.</p> <p>E2 stated, in interview on 7/2/04 at 9:00AM, that she was "suspicious" about the incident, because of the personal alarm and where it was found. E2 stated she told E1 that she thought the incident was "premeditated", as the alarm is very hard to remove from the chair. E2 stated that she was told by E1 that nothing went on; he (R6) didn't touch her (R10). When asked if she investigated the incident, E2 stated, in interview on 6/29/04 at 9:50AM, that she read the nurses notes and interviewed E25 but did not talk with any other staff or residents.</p> <p>E1 stated, in interview on 7/20/04, at 12:00PM, that she did not investigate or report the incident to the Department of Public Health, as she did not know what there was to report.</p> <p>E25 stated, in interview on 6/29/04 at approximately 10:00AM, that R6 was walking R10 toward the bed, that she intervened, put R10 back in her wheelchair and replaced the personal alarm and positioning device. E25 stated that the following day the documentation of the incident in the nurses' notes had been removed from R6's chart and that E1 was asking her and other nurses to alter their charting. E25, when questioned about whether she actually saw R6 push R10's wheelchair into his room, stated that no she did not, that R10 was already in the room when she saw her.</p>	F9999		

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F9999	<p>Continued From page 67</p> <p>E8 stated, in interview on 6/29/04 at 1:50PM, that she does not think that R10 is able to remove the positioning device from the wheelchair by herself. E8 stated that R10 is able to wheel herself around in the wheelchair.</p> <p>E18 stated, in interview on 7/2/04 at 8:35AM, that when the positioning device was first put on R10, they would find it half off of R10's wheelchair, but stated that she has not seen R10 take the positioning device off for a couple of months.</p> <p>R10's current physician order sheet states R10 has diagnoses of Alzheimer's disease and Cerebral-Vascular Accident. The comprehensive resident assessment dated 6/15/04, states that R10 has long and short-term memory problems with impaired decision-making ability and requires extensive assist of 2 to transfer and does not ambulate. The care plan dated 3/23/04 and 6/22/04 states that R10 wanders throughout the facility in her wheelchair. Surveyors observed R10 at different times during the day on 6/29 and 6/30/04; noting her using her feet and self-propel her wheelchair. R10 also wore a positioning device and a personal alarm.</p> <p>(4) Incident of Inappropriate Sexual behavior towards R8: E3 stated, in interview on 6/29/04 at 1:55PM, that she witnessed R6 standing in front of R8 while she was seated at a table in the dining room. R6 was talking to R8. E3 stated that R6 started just staring at R8, and then R6 started moving the lower half of his body (pelvic thrusting) in front of R8. E3 stated that R6 was fully dressed and did not touch R8. E3 stated she told R6 not to do that</p>	F9999		

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F9999	<p>Continued From page 68</p> <p>and he stopped. E3 stated that R8 just looked away and later asked to be seated at a table with just women. E3 stated that she reported the incident to E15 the next morning. E3 stated, in a 2nd interview on 7/6/04 at 4:45PM, that the incident with R6 and R8 happened on 6/22/04 in the evening. There is nothing documented about the incident in R6 or R8's nurses' notes.</p> <p>The current physician order sheet states that R8 has diagnoses of Atrial Fibrillation and Diabetes. The comprehensive resident assessment dated 6/30/04, states that R8 has long and short-term memory problems with impaired decision-making ability and requires supervision for transfers and ambulation.</p> <p>E1 stated, in interviews on 6/29/04 at 8:30AM and 7/20/04 at 12:00PM, that she was aware of the incident with R6 and R8, but did not investigate or report the incident to the Department of Public Health as she considered it a witnessed behavior that was redirected by staff.</p> <p>(5) Incident of Inappropriate Sexual behavior towards R7 (2 incidents): R7's current physician order sheet states that R7 has a diagnosis of Dementia. The comprehensive resident assessment dated 5/11/04, states that R7 has long and short-term memory problems with impaired decision making ability, wanders daily and requires supervision for transfers and ambulation. The care plan, dated as reviewed on 5/18/04, states that R7 has wandering behavior related to restlessness and confusion and also exhibits sexually inappropriate behaviors such as "groping, intimate kissing and removing clothing in front of male residents".</p>	F9999		

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F9999	<p>Continued From page 69</p> <p>Interviews of staff revealed that there have been 2 separate incidents involving R6 displaying inappropriate sexual behaviors towards R7.</p> <p>E3 stated, in interview on 7/2/04 at 8:55AM, that R7 was sitting on the couch by the wall and was crying. E3 stated that she asked R7 what was wrong and she (R7) replied, "He took his penis, but he wanted me to sleep with him". E3 stated that R7 was unable to say who did this, or describe anyone, but was pointing over by R3, who was sitting on the other side of the couch in his wheelchair. E3 stated that she reported the allegation to E2.</p> <p>E4 stated, in interview on 6/30/04 at 2:00PM, that on Saturday, 6/26/04, R7 alleged to her that right before she (R7) came into the dining room a "big man with white hair and a beard put a hanky down in her crotch, and tried to put his penis in, but she got away." E4 stated that R7 was fully clothed, but was shaking when she told her what had happened. E4 stated that from the description that R7 gave her, she thought the big man with white hair and the beard was R6. E4 stated that she called E1 at home and informed her of the allegation. E4 stated that E1 told her not to document the incident because R7 was confused and just to keep a close watch on R6. There is nothing documented in R6 or R7 's nurses notes about the allegation. E4 stated that although R7 has sexually inappropriate behaviors that she has never seen R7 approach R6.</p> <p>E2 stated, in interviews on 6/29/04 at 9:50AM and 7/2/04 at 9:00AM, that E3 reported to her an incident where R7 told E3 that the "man with white</p>	F9999		

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F9999	<p>Continued From page 70</p> <p>hair came near her and wanted to put his soldier in her." E2 stated that she talked to R7 and R7 was unable to tell her what man, but R7 got tearful and said, "he wanted something down here", and pointed to her perineal area. E2 stated that R3 was sitting in the dining room and that she did talk to him about R7's allegation and that he denied doing anything like that to R7. E2 stated that she talked to E1 about the allegation and inquired as to what she (E1) wanted E2 to do. E2 stated that E1 told her "You've asked everybody, it's proven invalid, just watch R7". E2 stated, in a 3rd interview on 6/30/04 at 3:40PM, that this occurred on 6/11/04. E2 stated, in the interview on 7/2/04 at 9:00AM, that she was not made aware of the 6/26/04 incident until 6/29/04. E2 stated that in her opinion R7 would not be able to give consent for sexual activity.</p> <p>R7 stated, in interview on 6/30/04 at 2:00PM, "There's a guy, he's still up doing things. He comes up by me and puts his peter out. I don't know what to do about him. He's a heavysset guy and he works out there on the place. The first time I felt him doing it, I just went home and cried." R7 was unable to provide any other details about the allegation.</p> <p>E1 stated, in interview on 6/30/04 at 2:30PM, that she was informed about the allegation made by R7, regarding the incident on 06/26/04, about the white haired man with the beard. E1 stated that she told E4 that R7 is confused. E1 stated that she did not do an investigation due to R7 being confused. E1 stated, in another interview on 7/20/04 at 12:00PM, that she did not report the 06/26/04 allegation to the Department of Public Health. E1 stated, during the interview on 7/2/04 at 10:00AM, that she did</p>	F9999			

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F9999	<p>Continued From page 71</p> <p>not do any further investigation of the allegation of 6/11/04 and did not report it to the Department of Public Health.</p> <p>(6) Policy, Procedure & Administrative issues related to these incidents: (A) Staff knowledge of R7's behaviors in general: E10 stated, in interview on 6/29/04 at 4:05PM, that she has seen R6 try to kiss R7 on the cheeks and lips for about 4 months. She reported R6's behavior to E25. E10 stated that she has never seen R7 "go after the men".</p> <p>E25 stated, in interviews on 7/2/04 at 11:45AM and 1:10PM, that she was aware R6 was trying to kiss and hold hands with residents, she had been notified of this by staff, and she had passed the information on to the next shift, but had not personally reported R6's behavior to E1. E25 stated that R6's behavior of kissing and holding hands with residents R11, R7, R10 had been occurring for about 2 months on her shift.</p> <p>E13 stated, in interview on 6/29/04 at 3:20PM, that while she was out smoking, R6 had threatened to tell on E13 for smoking where she wasn't supposed to smoke. E13 stated to R6, "I'm going to tell the police that you are fondling women here." According to E13, R6 responded saying, "What am I supposed to do [sexual expletive], [expletive], or what."</p> <p>E15 stated, in interview on 7/2/04 at 1:40PM, that R6 has been more outspoken and telling more stories in the last couple of months. E15 stated she was aware of R6's sexually inappropriate behaviors. E15 stated that R6 started classes at an outside agency on 5/3/04, 5 days a week. The</p>	F9999		

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F9999	<p>Continued From page 72</p> <p>agency refused to let him continue coming to the classes 5 days a week because of his behaviors, and decreased him to attending class once a week. E15 stated that she was told by the outside agency that R6 was not attending the classes, but going out and smoking, and they did not want to be responsible for him. When asked if there was any disagreement in the management team about R6, E15 stated that a few of us have been saying for about 3½ months that something needs to be done about R6. E15 stated that she told E1 that R6's placement in the facility was not appropriate for him any longer because he was becoming more psychiatric than medical. E15 stated that she feared R6 was going to leave the facility and something would happen to him or something would happen in the facility and R6 would harm a staff member or another resident. E15 stated that R6 had a lot of anger and R6's behavior kept escalating; she was worried that he was going to go "poof". When asked what E1's response to this information was, E15 stated that E1 would say she was aware of the problem and would speak to E21, or that we aren't going to do anything now because the census is too low. E15 stated that she thought that one of the times they had this discussion was at lunch.</p> <p>E2 stated, in interviews on 7/2/04 at 9:00AM and 7/8/04 at 11:40AM, that she had an informal discussion with staff shortly after she was hired in February 2004. She told them she did not think that R6 was appropriately placed, that he should be somewhere else where his needs could be better met. E2 could not remember whom she talked to at that time. E2 stated that she told E1 at a Department Head meeting that something needed to be done about finding another placement for R6,</p>	F9999		

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F9999	<p>Continued From page 73</p> <p>that R6 needed to go somewhere else 'soon'. When asked what E1's response was, E2 stated that E1 basically said that not until we get the census up are we going to look at that. E2 couldn't remember the date of the meeting, but knew that it was before June 2004. E2 stated that whenever they all met, that R6 was usually brought up.</p> <p>E22 stated, in interviews on 7/6/04 at 9:10AM and 7/8/04 at 10:50AM, that she thought there was a discussion in December 2003 about R6 and whether he was appropriately placed or not. E22 stated that it was her understanding that E1 was aware that some of us felt that R6 was not appropriately placed at the facility. E22 stated that every time something happened with R6 there would be a discussion on whether he should be at the facility or not. E22, when asked what E1's response to the discussion was, stated that she remembered overhearing E1 say at lunch that they couldn't move R6 because of low census.</p> <p>E1 stated, in interview on 7/6/04 at 11:40AM, that she had a conversation with E2; that she thought R6 needed to be somewhere and then they started to send R6 to a group, Monday - Friday, at an outside agency. E1 denied having any discussion with the management team about the teams' concerns that R6 was going to 'blow up' and cause harm to someone. E1 said that she would 'jokingly' say "you know we can't discharge him", but that she would never keep someone in the building if she really thought they might hurt someone. E1 stated that she made E27 aware of staff concerns about R6 being inappropriately placed.</p>	F9999		

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F9999	<p>Continued From page 74</p> <p>E1, E2, E18 and E26 all denied, at the daily status meeting on 7/2/04 at 3:10PM, of awareness that R6 had displayed behaviors of kissing or hugging R10, R11 and R7 or having witnessed any such behaviors by R6.</p> <p>(B) Policies & Procedures: The facility has a policy on Abuse addressing resident-to-resident abuse and investigation of abuse. The facility "Abuse" policy contains the following information: (a) The Administrator, Director of Nursing and Social Services will be immediately contacted regarding alleged abuse incidents. (b) The investigation will include the following protocol: "The investigating team (two or more people) will interview the resident involved; The investigating team will interview staff who may have been working at the time of the incident or immediately following the incident; The results of the investigation will be documented." (c) The Administrator will report the occurrence to the Illinois Department of Public Health with in 24 hours. "Results of the investigation will be reported to the Illinois Department of Public Health within 48 hours of the completion of the investigations." (d) "Any staff member or individual that observes a resident perpetrating abuse or neglect towards another resident, will immediately report the incident to the designated Abuse Coordinators. The perpetrator of the abuse will be immediately evaluated to determine the most appropriate therapy and/or placement while considering the safety of the perpetrator, other residents and employees of the facility." The facility neglected to implement this policy as it relates to the investigation component in these</p>	F9999			

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F9999	<p>Continued From page 75</p> <p>incidents & allegations of inappropriate sexual behaviors. The facility neglected to design or implement a specific training program or plan addressing R6's behaviors, with interventions identified to prevent repeated resident-to-resident incidents of inappropriate sexual behaviors and sexual fondling.</p> <p>The facility has a policy titled "Notification of Resident Change in Condition" which addresses the prompt notification of the physician when significant changes in the residents' physical, mental or psychosocial status are identified. This policy states: "The licensed nurse will immediately notify the attending physician when there is a significant change in the resident's physical, mental or psychosocial status." The facility neglected to implement this policy by not immediately notifying R6's physician of R6's inappropriate sexual fondling or increased inappropriate sexual behaviors in a timely manner.</p> <p>(D) Allegations that documentation was changed or removed from charts: E6 stated, in interview on 6/29/04 at 9:45AM, that a nurses' note was removed from R6's chart and he had been asked to rewrite documentation, but had refused to do so. E6 stated that in the note, E25 had described R6 doing an adulterous act to a resident. E6 stated that he refused to become part of a "cover up" and resigned.</p> <p>E1 stated, in interview on 6/29/04 at 8:30AM, that she had a discussion with E25 about what she charted regarding the incident between R10 and R6 and the fact that E25 did not actually see R6 push R10 into his room as she had charted. E1 stated that she has been talking to staff about their</p>	F9999		

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F9999	<p>Continued From page 76</p> <p>charting; "that you can't chart what you didn't see and not to assume anything, to only chart what you know." E1 denied that there was any documentation removed from the charts.</p> <p>(D) Transfer of R6 to another facility: R6 was transferred to another facility during this survey. Z3 stated, in interview on 7/7/04 at 9:40AM, that she had screened R6 for admission to their facility and that she was told by the discharging facility that R6 would make "sexual comments to the little old ladies", but it was verbal, nothing physical. Z3 stated that she was not told that R6 had a history of resident-to-resident sexual fondling.</p> <p>E15 stated, in interview on 7/8/04 at 10:15AM, that she told Z3 about R6 standing in front of a seated female resident and doing pelvic thrusting. E15 stated that she did not tell Z3 that R6 had been witnessed touching a R11s' perineal area, because she did not know that he had touched the resident. E15 stated that she was on maternity leave when the February incident occurred and was not aware of the specifics of the incident.</p> <p>(7) Elopement of R6 on 06/24/04: The nurses' notes dated 6/24/04 at 3:05AM state, "CNA reported she did [not] find [R6] on 2AM bed check, which was just completed. [R6] noted to be on patio with other residents at 12:30a.m." The police were notified at 3:20AM after staff conducted a search of the facility and the surrounding grounds then concluded that R6 was gone from the facility. Further notes, 3:25AM state, "Police officer here at facility, states they have resident located a few streets away and will bring resident back to facility." R6 was returned to the facility at 4:10AM</p>	F9999		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/26/04
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145371	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C. 7/22/04
NAME OF PROVIDER OR SUPPLIER ASTA CARE CENTER OF BLOOMINGTN			STREET ADDRESS, CITY, STATE, ZIP CODE 1509 NORTH CALHOUN STREET BLOOMINGTON, IL 61701		
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F9999	Continued From page 77 E14 stated, in interview on 7/8/04 at 3:00PM, that when she came to work on 6/23/04 at 10:30PM and at 12:30AM on 6/24/04 when she started bed check, R6 was outside the 200-Hall patio, sitting at a table by the gate, smoking. E14 stated that when she started the 2:00AM bed check, she checked on R6, but did not see him outside, but went ahead and finished the bed check. E14 stated that around 2:30AM she got to R6's room and he was not in there, so she went and checked outside on the 300-Hall smoking area, but R6 was not outside. A room-to-room search was then started and the nurse was notified. E14 stated that the police found R6 at a local motel over by the highway. E14 stated that when R6 returned he told her that a "recruiter had taken him down there and had signed him out." E14 stated she was not aware whether R6 wore an electronic monitoring device or not and stated that R6 did not need to be supervised to smoke. E14 stated that they were supposed check on R6 to make sure where he was, and that she checked him every 2 hours. E21 stated, in interview on 7/8/04 at 8:25AM, that when she came to work on 6/23/04 at 10:00PM R6 was sitting out on the 200-Wing patio with some other residents. E21 stated that she saw R6 every 20 to 25 minutes, from the window, until 12:30AM. E21 stated that at one point, R6 came into the facility to go to the bathroom and the alarm did not go off, so she knew that he did not have an electronic monitoring device on. E21 stated that she did not know that R6 was supposed to have an electronic monitoring device; it had been removed in April and she was not aware that it had been put back on. E21 stated that after 12:30AM she got busy doing treatments and other things and did not	F9999			

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F9999	<p>Continued From page 78</p> <p>walk by that location, therefore did not see R6 any longer. E21 stated that when they discovered R6 was missing around 3:00AM she instituted a facility-wide search and did a head count of each hall, with R6 remaining unaccounted for. E21 stated she then notified E1 and called the police to report R6 missing. E21 stated that she examined R6 when he was returned to the facility and he was not injured, but was delusional. E21 stated that R6 was not on the elopement list posted at the nurses' station or in the 'Out and About' book located at the nurses station. The 'Out and About' book contains a picture and information about residents at risk for elopement. E21 stated that she thought that R6 could sign himself out and leave if he chose to.</p> <p>The 200-Hall patio is located outside of the nurses' station. There is a large window in front of the nurses' station facing the patio. The patio area is fenced with a gate located at the outer aspect of the area, near the employee parking lot. The gate is kept closed, but not locked, and is used by staff as they arrive and leave the facility. There are several patio tables in the area, with one of them being located within a couple of feet from the gate.</p> <p>Z9 stated, in interview on 7/9/04 at 6:17AM, that at around the same time the facility called and reported R6 missing, the dispatcher received a call from a motel saying they found a male roaming the halls. Z9 stated that while he went to the facility another officer went to the motel and found R6 in the bathroom washing his face. When asked if he talked to R6, Z9 stated that R6 told him that "a guy dressed in battle uniform and covered in decorations, the General, came into the [facility] and signed him out." When asked if he thought</p>	F9999		

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F9999	<p>Continued From page 79</p> <p>R6, in his present state of mind (i. e., delusional), was safe to be out, Z9 stated, "I would probably say he was not safe." Z9 stated that he thought that R6 needs a "little more supervision." Z9 stated that R6 did not want to go back to the facility, but that they were finally able to convince him to go back.</p> <p>E28 stated, in interview on 7/8/04 at approximately 11:00AM, that when she came to work on 6/23/04 at 10:15PM she saw R6 and he told her that she was "the prettiest lieutenant in his army."</p> <p>E29 stated, in interview on 7/8/04 at 10:00AM, that when he came to work on 6/23/04 at 10:15PM R6 was sitting at a table near the gate on the patio outside the 200-Hall. E29 stated that the gate was closed but not locked. E29 stated that he was not aware that R6 needed to be supervised.</p> <p>E8 stated, in interview on 7/8/04 at 2:20PM, that she thought R6 did not have to wear an electronic monitoring device, as he had been good about not going anywhere. E8 stated that R6 was able to smoke unsupervised.</p> <p>R6 stated, during interview in the facility on 6/29/04 at 10:20AM, "A man wanted me to go to Africa. I like old people. 400 [hall] is full of disease-gonorrhea. I like to hunt and fish. I'm affiliated with the FBI-getting information from [them]. I'm also a bone welder-got a big machine, [using] gold, silver, brass, wrapping in human tape. I've been a M.D. [Medical Doctor] all my life." R6 was observed to be very delusional throughout the interview and it was difficult to have a lucid conversation with R6.</p>	F9999		