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	14E245	A. BUILDING ____ B. WING ____	C 06/30/2006

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A R C OF JACKSONVILLE, LTD, THE	**1320 TENDICK, P O BOX 1115 JACKSONVILLE, IL 62650**

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F 490	Continued From page 56 procedures in the employee handbook. Review of the personnel file showed E7 continued to work after R1 returned to the facility; last day worked was 04/17/06; 17 days after R1 returned to the facility. Review of the Nursing 2005 Drug Handbook showed the medication Klonopin should not be discontinued abruptly as withdrawal symptoms could occur. Review showed the medication Zoloft should not be stopped abruptly as adverse effects such as nausea, headache, and malaise could occur. The Immediate Jeopardy situation was identified on 06/26/06. The Immediate Jeopardy was determined to have begun 02/11/06 when E7 began taking R1 out of the facility from early morning to late at night. E1 was informed of the Immediate Jeopardy on 06/27/06 at 1:40p.m. The surveyor confirmed through observation, interview, and record review, the facility took the following steps to remove the Immediate Jeopardy: 1. On 06/26 and 06/27/06 an inservice was given to staff on Abuse Prevention and Abuse Investigation. 2. On 06/26/06 all residents received an inservice on Abuse Prevention. 3. On 06/27/06 a "STAFF FRATERNIZATION " policy was written and staff were given a copy of the facility's new "STAFF FRATERNIZATION POLICY." 4. On 06/26/06 the facility reviewed their abuse policy.	F 490		
F9999	FINAL OBSERVATIONS	F9999		

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LICENSURE VIOLATION

300.510 e)
300.1210 a)
300.3240 a)
300.3240 e)

300.510 Administrator

e) The licensee and the administrator shall be responsible for seeing that the applicable regulations are met in the facility and that employees are familiar with those regulations according to the level of their responsibilities.

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 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.

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)

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

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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 requirements are not met as evidenced by :

Based on observation, record review and interviews, the facility failed to prevent sexual and financial exploitation of a male resident (R1) by a female licensed staff person. The facility further failed to implement its abuse prevention policies, failed to investigate this incident thoroughly or timely, and failed to have an effective administration that recognized these abuses. The facility allowed a female licensed staff person to develop a personal and sexual relationship with a male resident. The facility continued to allow the licensed staff person to work in the facility, and care for R1. R1 discharged himself from the facility, withdrew all the money from his bank account and moved in with the licensed staff person. He returned to the facility 18 days later. The failure of the facility to follow their employee conduct policies and their abuse policies, and to counsel R1 resulted in R1 being extremely depressed, withdrawn and anxious. These failures also led to R1 having his psychoactive medication increased.

Findings include:

Review of R1's physician orders showed diagnoses, in part, of Anxiety Disorder, Alcohol Dependency, Psychosis, Korsakoff's Dementia, Alcohol Related Psychosis, Depression and Antisocial Personality Disorder.

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Continued From page 59

Review of R1's 08/05/04 through 4/3/06, " ASSESSMENT for RESIDENTS AT RISK for INCIDENTS," showed R1 is easily distracted; has fair recall; has difficulty making decisions; did not want to answer any questions; has average judgment skills; needed verbal cues and supervision to perform activities of daily living; is not sexually active; and does not have any documented mood or behavior concerns. R1 is oriented at times; requires verbal supervision for activities of daily living; is not able to be outside the facility unattended related to confusion at this time; is withdrawn and depressed at times; is occasionally verbally aggressive; and has poor impulse control.

R1's Minimum Data Set (MDS) dated 3/2/06, which was done prior to his discharge, shows he did not have any periods of lethargy, anger, unpleasant anger, unpleasant moods, sad, pained or worried facial expressions; was not verbally abusive; and did not resist care. Review of the initial MDS dated 04/13/06, after his return to the facility on 03/31/06, showed R1 with a decline in cognitive status. He is now assessed as moderately impaired cognitively; has periods of lethargy as well as his mental functioning varying over the course of the day; has persistent anger with self or others; an unpleasant mood in the morning; sad, pained, worried facial expressions; is verbally abusive; resists care less; and his behavior is not easily altered.

Review of the Resident Assessment Protocol (RAP) for Delirium showed documentation R1 recently left the facility against medical advice and did not receive his medication for 18 days, but since returning to the facility and receiving his

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F9999	Continued From page 60 medication his behaviors have improved greatly. Review of the Cognitive Loss/Dementia RAP dated 04/13/06 showed documentation R1 is moderately impaired cognitively, and remains in bed all day. Review of the "SOCIAL PROGRESS NOTES" dated 09/08/04 showed documentation R1 needs some help with decision making and has a long and short term memory problem; 03/03/05 note documented he needs assist with decision making and has a short term memory problem. Review of the discharge plan which was updated on 12/03/05 showed documentation, in part, that R1 needs 24 hour supervision, is forgetful, confused, withdrawn, and needs supervision with safety, mathematics, and reading. He is dependent for medicating and cooking; has problems with budgeting, finances, goal setting, impulse control, nutrition, and appointment making; needs improvement in behavior and impulse control, social functioning, community living skills; needs facility programming; has a history of substance abuse; and is not a good candidate for discharge at this time. Review of the nurses notes showed documentation between 01/21/06 and 3/10/06, that R1 was out 19 times with E7, for all or most of the day. Nurses note of 03/13/06 at 9:20a.m. documented R1 left the facility with his belongings after signing out against medical advice, "information on form" read to R1 and he verbalized understanding, left per taxi.	F9999		

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F9999	Continued From page 61 Review of R1's entire current clinical record and review of the previous clinical record showed R1 did not receive any counseling, and/or programming of any kind although he was identified as needing programming. The "RELEASE FROM RESPONSIBILITY For DISCHARGE AGAINST MEDICAL ADVICE" form R1 signed on 03/13/06 at 9:20a.m. showed R1 initialed he was informed he had received his $30.00 for March 2006, he acknowledged he would not be sent with any medication, and he was taking all of his possessions and finances. R1 wrote on the back of the form the address he was going to, and the address was E7's and he would get to his destination through E7. R1's resident account ledger showed he received $2000.00 on 12/16/05 and withdrew $900.00 on 12/23/05, $50.00 on 01/19/06, $200.00 on 02/09/06, and $716.30 on 02/23/06. R1's 03/31/06 admission nurses notes showed R1 returned at 12:10p.m. with no medication and no valuables. Nurses notes from 3/31/06 through 4/26/06 show R1was in bed most of the day, was withdrawn, complained of feeling terrible, had poor hygiene, was up in the middle of the night, was sometimes confused, and refused meals and fluids. R1's Medication Administration Records (MAR) for February through March showed R1 received, in-part, Seroquel 500mg. twice daily (antipsychotic agent), Klonopin 1mg. three times daily (Psychosis), Vistaril 25mg. three times daily (Anxiety), Zoloft 100mg. daily (Antidepressant), and Remeron 30mg and SolTab once daily (Depression).	F9999		

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F9999	Continued From page 62 Physician's orders after R1's return to the facility showed his Zoloft was increased to 150mg. and his Remeron to 45mg. On 4/21/06 at 8:00p.m. an order was received to discontinue Seroquel and start R1 on Haldol 5mg. twice daily. R1 continued to stay in bed, refused offered fluids, asked to be left alone, was anxious and short tempered, was up stating he could not sleep, complained of anxiety that medicine is not helping, refused lunch, was in bed much of the time, voiced complaints of not being able to sleep at present time, stated "I need something I can't keep going like this, f--- place keeps me up." Review of Z5's order for 04/27/06 showed Z5 increased R1's Zoloft from 100mg every day to 150mg. every day due to his depression, and increased his Remeron to 45mg. every hour of sleep. During interview of R1 on 06/23/06 at 10:14a.m. he stated he was not coerced in any way to leave the facility and no one asked him for any money, but he did give $700.00 to E7's lawyer to pay for her divorce. R1 stated when he was living with E 7, she did provide him beer but he could not drink much because it made him sick. E7 stated he did not remember taking $900.00 out of his account in December 2005 but it was his signature showing he did get the money. R1 stated the facility did try to get him not to leave the facility on 3/13/06, but he went anyway. He stated he was going to take E7 to small claims court to get his money back as he was saving that money for an apartment and that he does not know what he will do now. When asked again if E7 asked him for any money he stated no but E7 did state to him several times if she could get a divorce they	F9999		

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F9999	Continued From page 63 could get married. R1 stated he and E7 talked a lot about him leaving the facility and living with her and decided when he would leave the facility. R1 stated after the relationship ended with E7 he was very sad and depressed and admitted it was "kinda" hard when she worked. He went on to say that after he returned to the facility, he stayed in bed a lot. R1 stated he and E7 had a sexual relationship even before he left the facility to go and live with E7. He stated he did inform E7 he had some money but did not remember if he told her how much money. R1 stated he still misses E 7. R1 stated while he was out of the facility he went to the hospital and was there for hours and he did not remember what medicine he was placed on. While R1 was being interviewed it was noted when he was speaking of E7 and the relationship he was sad and would look down at the table. When he was not speaking directly about E7 he would look the surveyor in the eyes. During an interview of E4, Administrator, on 06/ 23/06 at 9:20a.m., he stated R1 is his own guardian and signed his own AMA (Against Medical Advice) form. E4 stated he explained to R1 he would be leaving without his medication, there would be no one to assist him as E7 worked, and he did not believe it was a safe environment. E4 stated he counseled E7 several times as E7 would take R1 out on pass at 6:45a. m. and bring him back when she came back to work at 10:45p.m. E4 stated he told E7 she could not supervise R1 as she could not stay up 24-48 hours at a time. E4 stated R1 got a large sum from Social Security disability, he "believes $2000.00." E4 stated R1 paid for E7's divorce and R1 confirmed this when he returned to the facility. E4 stated he did not remember the facility having a written policy on resident to staff	F9999		

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F9999	Continued From page 64 relationships but they "discourage it." E4 stated they tell staff it really is not ethical and could mean "their license." E4 stated R1 telephoned him and asked to return to the facility. When he returned in a taxi he was "extremely depressed and withdrawn" and he stayed in his room for the first 24 hours. E4 stated when he finally told E7 she could not take R1 out of the facility all day, she was a no call, no show. E4 stated E7 told him she got a better job with a home health agency. E4 stated at first he supported and encouraged E7 taking R1 out for a hour or so as she was married and he never dreamed she would develop a relationship with the resident. E4 stated R1 got attached to the former care plan coordinator (E17), who was also a Licensed Practical Nurse, E17 would take R1 out for a meal and when E17 left employment R1 "got depressed," and he felt R1 was interacting again with E7. E4 stated he called the Department of Professional Regulations on E7 as he believed she "used the resident." E4 stated he believed E7 maybe was giving R1 beer and E7 knew R1 had Korsakoff Dementia and she also knew his mental status. E4 stated he believed R1 understood the AMA and that he was not coerced in leaving. E4 stated he had R1 sign a contract when he returned that he would not fraternize with staff anymore. During interview of E2 Registered Nurse/Director of Nurses (RN/DON), on 06/23/06 at 8:41a.m., she stated E7 worked from 10:45p.m. to 6:45a.m. E2 stated she did not know how long E7 and R1 had been in a relationship, but initially E7 was taking R1 out on pass during the day for brief periods of an hour or two and then the passes got longer. E2 stated R1 did not have to sign the passes; E7 signed R1 out. She stated R1 could	F9999		

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F9999	Continued From page 65 possibly take his medication but it is questionable, so E7 was given R1's medication when he left the facility on pass to ensure R1 was given the medication at the correct time. E2 stated R1 is responsible for himself. She stated she believed E7 told R1 they were going to get married so that is why he left with her; she stated R1 told her this. E2 stated R1 signed the AMA and the AMA was explained to him. E2 stated R1 was told it was not a good idea for him to leave. E2 based this on her knowledge of E7's home life and it did not seem like a stable home life. E2 stated E7 had a husband and is raising a grandchild with disabilities, has children with criminal history and "other problems." E2 stated E7 was not present when R1 left AMA; R1 left in a taxi. E2 stated at first R1 would not say where he was going but E4 told him he needed to know so R1 wrote the address on the back of the AMA and it was E7's address. E2 stated while R1 was gone from the facility he was admitted to the hospital with pneumonia. E2 stated when R1 returned to the facility he looked terrible, his skin color was gray, and he went to his room and put his head under the covers. E2 stated when R1 returned to the facility he was "very nervous and anxious" and he stated he did not feel good. He stated "I feel awful, I feel awful." E2 stated R1 had been off his "psych meds." E2 stated R1 told her he had been on no medication. E2 stated R1 was "very depressed and very anxious." E2 stated when R1 was living in the facility, prior to the 03/13/06 discharge, he would stay up all night with E7. E2 stated E7 would bring R1 food from home and he was eating well. E2 stated R1 has Psoriasis and when he returned to the facility it was worse and he had lost some weight. E2 stated R1 went from being depressed to being angry at E7. E2 stated for awhile R1 tried to get	F9999		

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hold of E7 but he could not. E2 stated she did not know of the current status of telephone calls or the relationship. E2 stated R1's mood is better and he is not despondent or depressed and he stated he feels good. E2 stated R1 told her he paid for E7's divorce and he thought they were going to get married. E2 stated R1 was taking out large sums of money from his account at different times and he has nothing to show for it. E2 stated R1 was taking money out of his account prior to leaving the facility, "several hundreds" at a time; she felt he knew how much money he had. E2 stated after R1 returned to the facility he still had a key to E7's house and he went over there as he heard she had a new boyfriend; he stated his beer had better still be there. When he returned he told E2 his beer was gone, there were beer cans all over the floor and it was a new brand of beer. E2 stated E7 or someone called the police on R1 as the police told her they received a call E 7's ex-boyfriend was in the house. E2 stated the police brought R1 back to the facility and believed the police took the house key. E2 stated E4 reported E7 to the Department of Professional Regulation. During the interview it was verified with E2 that R1 had been involved with another staff person (E17) and when the relationship ended R1 became very depressed and withdrawn resulting in him not eating or drinking which resulted in him being hospitalized with dehydration.

During interview of E3, LPN, on 06/23/06 at 7:40 a.m., she stated E7 worked the night shift. E3 stated for two or three weeks before R1 left the facility, when E7 would get off work (6:45a.m.) she would frequently take R1 home with her and bring him back when she came back to work (10: 30p.m.). E4 stated E7 told her she had

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F9999	Continued From page 67 permission from E4 and E2 to take R1 out and she had a written contract with them there would be no inappropriate behavior in the facility. E3 stated she overheard E7 tell E19 (Care Plan Coordinator) she and R1 were in love and they were going to get married and she (E7) did not care what anyone thought. E3 stated R1 returned to the facility in a taxi and he "was a mess." E3 stated R1 wanted to return to the facility as he had no medication. E3 confirmed R1 is his own guardian, could make his own decision to leave, but could not live on his own. E3 stated R1 was " very upset" when he returned as E7 would call and say she was going to pick him up and she never did plus he found out E7 had another man to move in with her. E3 stated R1 would just lay in bed and not come out of his room for approximately the first two weeks. E3 stated R1 stated he gave E7 $700.00 to pay for her divorce; his plan was to get her divorced and marry her. E 3 stated she was unaware if there is a facility policy on staff to resident relationships. During interview of E1, Administrator/Qualified Mental Health Professional, on 06/23/06 at 9:05a.m., she stated R1 signed the AMA and he understood it. E1 stated she did not believe there was any coercion to get R1 to leave by E7, or anyone else, and since R1 left AMA the policy is to not give the resident any medication upon discharge. E1 stated R1 has occasional verbal aggression (cussing) but no other inappropriate behaviors. She believed E4 called Public Health and someone called the Department of Professional Regulation as they had called the facility trying to find E7. E1 stated R1 is his own guardian and she believed his cognition is well enough to be responsible. E1 stated R1, while he was gone from the facility, lived with E7. E1 did	F9999		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 68	F9999		

not know how long the relationship had been going on as she first found out about the relationship a few days before he left the facility. E1 confirmed E7 worked the night shift and R1 would sleep a lot during the day and would stay up with E7 all night. She did not know of any inappropriate (sexual) behavior going on with E7 and R1 in the building. E1 stated R1 would go out during the day with E7 and E7 would sign she was responsible then they could send the medication with him. E1 stated when R1 was discharged there was no medication sent with him as he was leaving AMA and Public Aide would not allow medication to be sent with a resident upon discharge. E1 stated R1 returned to the facility by taxi and stated "It just wasn't working." E1 stated R1 took out a large sum of money when he left, and R1 stated he was going "to get some stuff and help (E7) with some stuff." She speculated he was going to pay for E7's divorce. E1 stated when R1 returned to the facility he was "lethargic and depressed," and he just stayed in bed for a couple of days. E1 stated E7 then started calling R1 and he was happy about it. E7 also called a couple of times and said she (E7) was going to visit and then called and cancelled. E1 stated the facility has a policy once terminated from employment you are not allowed back in the facility. E1 stated E4 was the Administrator when R1 left and returned to the facility. E1 stated she does not believe E7 coerced the resident in any way. E1 could find no written policy on a resident not being able to be discharged with medication.

During interview of E10 Laundry Supervisor on 06/26/06 at 8:25a.m. she stated she observed R1 and E7 in R1's room kissing. E10 stated she reported this to E4 and E4 did not say anything

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	14E245	A. BUILDING ______ B. WING ______	C 06/30/2006

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F9999	Continued From page 69 but went down the hall toward R1's room. E10 believed this was about one week prior to R1 discharging himself from the facility. E10 was unaware of of the relationship prior to her observation and was unaware of what E4 did after he was informed. During interview of E11, on 06/26/06 at 2:40p.m., she stated E7 told her she (E7) and R1 were having a sexual relationship. E11 stated she made a statement to E7 that R1 was "on so many psychotropic medications so how can he do it" referring to sexual intercourse and E7 stated " believe me he can do it." E11 stated E7 told her she was going to take R1 out of the facility and that R1 wanted to pay for her divorce. E11 stated E7 called on the pay phone since R1 returned and since E7 is no longer employed, she would not allow R1 to speak with E7. E11 stated the night aides (could not remember names), would tell her R1 would sit in the nurses station and dining area at night when E7 worked and smoke which other residents did not like as they could not smoke. E7 would go into R1's room at night. E11 stated she did not know if the Administrator and Director of Nurses knew of the relationship between R1 and E7 but "am sure they did as would have had to be blind not to." E 11 stated R1 told her he paid for E7's divorce. E 11 believed she spoke with E4 and E2 but they " just brushed it off" or would say it's the residents right. E11 stated when R1 returned to the facility on 03/31/06 he was "like a zombie" as had been off his psychotropic meds for so long. E11 stated R1 would cover his head and stayed in his room for "about two weeks." During interview of E9 Psych Rehabilitation Service Aide (PRSA), on 06/26/06, she stated R1	F9999		

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F9999	Continued From page 70 was not in any programs and had no behaviors being tracked. E9 stated E1 was the QMHP prior to becoming Administrator and at this time the facility does not have a QMHP. E9 stated occasionally R1 is verbally abusive but never acts out on his threats. E9 stated when E7 worked in the facility R1 would sleep all day and stay up with E7 all night. E9 stated she was aware R1 and E7 were having a relationship for three or four months, not really realizing it was sexual. She stated she was told by the nurse on second shift (E11), that E7 told her the sex was good. E9 stated everyone knew about the relationship between R1 and E7. E9 stated E10 caught E7 and R1 in an embrace and E4 escorted E7 out of the building just before R1 discharged himself. E9 stated she did see the resident's money pass and she was the one who went to the bank and got the $700.00 for R1 and advised him not to take out that much but he did. E9 stated when R1 returned to the facility he " was a mess"; he had no medication for three weeks. E9 stated R1, upon return to the facility, looked gray, pale and thin and stated he did not feel good; "he just could not function." E9 stated E7 and R1 had planned the discharge of R1. R1 stated he gave all of his money to E7. E9 stated R1 had another relationship with an employee (E 17) as E17 would take him out for meals, to the casino, and buy him cigarettes, and he would sit in her office for hours. E9 stated when R1's and E17's relationship was over R1 became very depressed and R1 had to go to the hospital for dehydration; would stay in his room and not eat, and covered his head. During interview of E15, Certified Nurse Aide (CNA), on 06/27/06 at 1:20p.m., per telephone, she stated E7 would go into R1's room at times	F9999		

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F9999	Continued From page 71 and even though the door was slightly ajar she could not see what was going on. She stated she did see R1 and E7 kiss a couple of times, once in the nurses station and once in the hallway, and that E7 did talk of taking R1 home with her. E15 stated E7 told her once around Christmas R1 tried to give her some money but she did not take it, and she did not know if E7 took it or not. E7 had stated R1 tried to give her money as a gift. E15 stated the Administrator (E4) and the D. O. N. (E2) both knew what was going on; "everybody knew." E15 stated E7 would allow the resident (R1) to smoke during the night and the other residents did not like this as they were not allowed to smoke. During interview of E5 Bookkeeper/Receptionist on 06/23/06 at 10:26a.m. she stated she did not know why R1 took $900.00 out of his account in 12/05 or the $700.00 in 02/06 as she cannot ask residents what they do with their money as it is their right to use it. During interview on 06/23/06 at 2:25p.m. E5 stated she spoke with R1 about the safety of his money when he took out large sums but no counseling was done over his finances. E5 stated prior to her current position she was the Social Service Designee. Review of the facility's "Abuse Prevention Program" "Facility Policy" showed documentation, in part, "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 will be done by: identifying occurrences and patterns of potential mistreatment; immediately protecting residents involved in identified reports of possible abuse; implementing systems to investigate all reports and allegations of	F9999		

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F9999	Continued From page 72 mistreatment promptly and aggressively, and making the necessary changes to prevent future occurrences; and filing accurate and timely investigative reports." Review of the "Employee Handbook" showed documentation, in part, "..... Anything less than professional behavior is not only inappropriate but is a hindrance to the quality care and well-being of all concerned. It is each employees's responsibility to report violations of our personnel polices, safety regulations, operational policies and procedures, resident abuse, etc., to his/her supervisor. The department director and/or Administrator shall prepare a written report of any counseling session. The department director and/or Administrator shall prepare a written reprimand outlining the infraction, what action is needed to resolve the infraction, the employee's account of what happened, and the signature and date of the employee and supervisor. The department director shall submit a copy of the counseling session to the Administrator for review. A copy of the written reprimand shall be provided to the employee, and a copy shall be be provided to the office manager for inclusion in the employee's personnel record.. One reason that could result in a written warning, suspension or discharge from employment: 'Conduct or behavior unbecoming to your position, or unbecoming to an employee of the health care institution,' 'Accepting any type of tip or gratuity from a resident or his/her family or friends,' or 'Borrowing or using any personal belongings of a resident including the borrowing of money'." Review of E7's personnel file failed to show any counseling sessions or disciplinary actions showing she had not followed the facility's policy/	F9999		