STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145705	A. BUILDING _____ B. WING _____	C 03/18/2010

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VIRGIL CALVERT N & REHAB CTR	5050 SUMMIT AVENUE EAST SAINT LOUIS, IL 62205

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F 520	Continued From page 140 15. The facility failed to assist 2 (R2, R4) of 2 residents reviewed that required transportation to a surgical procedure. Review of the facility policy and procedure titled "Quality Assurance and Improvement" dated 12/4/07 states that the goal is "To develop a system that continuously improves the quality of care and quality of life for residents in this facility. This system will be achieved through quality management. Quality management is a systematic, pro-active process of accessing, controlling, and improving outcomes. The system will focus on health care outcomes, resident satisfaction, and operational efficiency". Objectives include, in part, to implement a system "whereby negative outcomes are identified and appropriate monitoring, analysis, and corrective action are taken". Review of the dates of the facility quality assurance committee meetings noted that the quality assurance committee had met on 4/15/09, 7/22/09, and 1/29/10. E1, Administrator, stated on 3/11/10 at 11:30 AM that there was no information available regarding identification of the above deficiencies through their quality assurance process.	F 520		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.690a) 300.690b) 300.690c) 300.695a)1)3) 300.695)b)2) 300.3240a)	F9999		

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F9999	Continued From page 141 300.3240b) 300.3240c) 300.3240d) 300.3240f) Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. Section 300.695 Contacting Local Law Enforcement a) For the purpose of this Section, the following definitions shall apply: 1) "911" - an emergency answer and response system in which the caller need only dial 9-1-1 on a telephone to obtain emergency services, including police, fire, medical ambulance and	F9999		

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F9999	Continued From page 142 rescue. 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). b) The facility shall immediately contact local law enforcement authorities (e.g., telephoning 911 where available) in the following situations: 2) Physical abuse involving physical injury inflicted on a resident by another resident, except in situations where the behavior is associated with dementia or developmental disability; 3) Sexual abuse of a resident by a staff member, another resident, or a visitor; Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. 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. c) 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. d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a	F9999		

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F9999	Continued From page 143 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. These regulations were not met as evidenced by: Based on record review, observation and interview it was determined that the facility failed to protect 6 (R7, R17, R8, R10, R13, R14), residents from sexual abuse from R6, R9 and R11. This failure resulted in 5 (R7, R8, R13, R14, R22) residents being subjected to unwanted sexual contact and 1 (R10) moderately impaired resident being exposed to a sexually transmitted disease. The findings include: 1. According to the medical record, R6 was admitted to the facility on 2/5/04 with diagnoses, in part, of dementia, stroke, and Alzheimer's Disease. The Minimum Data Set dated 11/13/09 assessed R6 as mildly cognitively impaired with no socially inappropriate behaviors noted. R6 is an identified offender. R6 is ambulatory. Documented on the care plan for R6 dated 4/16/09 was "found in female rm (room), sitting on her bed (with) curtain pulled attempting to stroke her arm. Removed from rm (and) chg (change) made to another hall." There was no incident report as confirmed by E2, Director of Nursing, on 2/23/10. There are no nurses notes regarding the incident.	F9999		

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F9999	Continued From page 144 E5, Social Service Director, stated on 2/23/10 at 9:30 AM that she was coming down the hall on 4/16/09 and saw two pair of feet behind a curtain that was pulled. E5 stated that R6 was rubbing a confused lady's (R22's) shoulder. E5 stated she was not aware of any other incidents with R6 touching the female residents. E5 stated they keep an eye on him and he was moved to the mens hall. E5 confirmed that R6 is an identified offender. E5 provided a copy of the "Criminal History Analysis" done on 11/17/06 which assessed R6 as a "low risk." E5 stated that she did not recall the incidents of 8/1/09 or 11/21/09. There are no Social Service notes for the 8/1/09 or the 11/21/09 incidents. The "Social Progress Notes" dated 4/16/09 confirmed the incident and noted that R6 was moved to another room. The note dated 4/17/09 stated that a meeting was held with R6, E1, Administrator, E2, Director of Nursing, E19, Quality Assurance Nurse and E5, Social Service Director. E5 stated in the note that R6 was told that he should not go into a female's room that is not cognitive. The social service note stated, "If an individual has displayed cognitive impairment, that person is incapable of being consenting. It was also mentioned that if anything was to happen, he could be charged with assault because the female did not know what she was doing." R6 was noted to voice an understanding. The care plan dated 4/16/09 stated as approaches/interventions to "monitor him to ensure he is not in any females rm (room)," "notify SW (social worker) immediately for any further inappropriate behaviors," and on 5/22/09 to "monitor to ensure females do not go to his	F9999		

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F9999	Continued From page 145 room." The goal was documented as "(R6) will not be in any female rms thru 5/27/09." The care plan dated 12/3/08 documented on 8/16/09 that on "8/1/09 resident found with another female resident kissing her. (Z5, Psychiatrist) saw on 8/6/09 (and) wrote orders for." An additional approach of "Close constant face checks every 15 minutes to monitor where abouts when in facility. Discontinued 10/15/09." There was no social service notes. The nurses notes dated 8/1/09 at 3:30 AM noted that "Resident reported to have inappropriate sexual behaviors, (Z6, physician) notified." There were no further additions to the care plan. The only 15 minute check documentation E2 could provide was for August, 2009, September, 2009 and January, 2010. The documentation for each month is incomplete. The physician progress note dated 8/6/09 by Z5, Psychiatrist, stated that R6 was seen for an emergency evaluation for "sexually inappropriate behavior." The note states that a letter from the nurse states, "This nurse was walking past activity room to go and put my lunch bags in Employee Break room. I noticed when I walked past activity room (R6) bent over kissing (R7) in her mouth, (R7) just sitting there with her arms folded across chest and stomach area." E5, Social Service Director, stated on 2/23/10 that she did not recall that incident. E2 stated on 2/23/09 that R6 saw the doctor but she did not make out an incident report for the 8/1/09 incident. E2 stated that Z5 started R6 on Provera for his sexual behavior. The physician order sheet notes that the Provera 20 milligrams was started on 8/13/09. There is no documentation in	F9999		

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F9999	Continued From page 146 the attending physician's (Z6) progress notes dated 5/16/09, 6/28/09, 7/31/09, 8/31/09, 9/30/09, 10,31/09, 11/29/09, 12/31/09 and 1/31/09 regarding the sexual behavior. The nurses notes dated 10/15/09 by E17, Minimum Data Set Coordinator, stated, "Reviewed residents charts behaviors to determine continued need for 15 minute face checks and it was determined that he had not been involved in activities that warrant need for. Face checks discontinued." On 10/26/09 the "Social Progress Notes" dated 10/26/09 state that R6 was accused of "inappropriately touching female residents that (are) unable to give consent to be touched." The note states that "As usual, resident denies doing it." E1, Administrator, met with R6 to explain the severity of his actions and that it would not be tolerated. There are no additions to the care plan. E2 confirmed on 2/23/10 that there was no nursing note or incident report, nor was she aware of the incident or the Department being notified. The care plan with a review date of 11/14/09 states as a "Behavior Problem" that R6 "has been found, more than once, kissing and fondling a female resident that is cognitively unable to give informed consent. He has been counseled and placed on Provera BID (twice a day) to help decrease libido. He has been recently refusing medications, the Provera included and refuses to see Psych MD (Psychiatrist)." The goal listed was "Resident will not engage in sexual activity with any female residents that are cognitively unable to give informed consent and will take his medication as prescribed thru 2/14/10." The	F9999		

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F9999	Continued From page 147 "Approaches/Interventions" only address if the behavior has already happened and not how to prevent the behavior. The "Approaches/Interventions" to the care plan dated 11/14/09 include to administer medication as ordered, have family members explain the consequences of his behavior, give him a time out if he becomes angry, if sexually inappropriate let him know his behavior is unacceptable, invite to activities, consult with the Psychiatrist as needed, remind him that the behavior has been discussed with him and he needs to abide by the rules, social service to intervene as needed, educate on the importance of medication compliance, and "He will often deny he is doing anything wrong, so he will need to know about witnesses and what is inappropriate." The 15 minute checks were discontinued on 10/15/09. The "Behavior Rap Module" dated 11/14/09 states under the comments that "(R6) has been demonstrating some problematic, inappropriate sexual behaviors in the last 6 months that have targeted a female resident unable to give informed consent. He has been observed kissing and fondling the breasts of this female and despite counseling and medication adjustments continues to make advances that staff must intervene on. He currently receives Provera BID (twice a day) to decrease his libido, however he has recently been refusing some of his medications including the Provera. It has been discussed with him the repercussions for his actions leading up to 30 day discharge but he does not appear to care...." On 11/21/09 the facility "Reporting Form" states "11/21/09 Res (resident) found grabbing the	F9999		

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F9999	Continued From page 148	F9999		

breasts of a female resident in the activity room by the activities asst. (assistant). This nurse was then informed of the incident by the activities asst. Res. was encouraged by this nurse to refrain from being sexually inappropriate. Res. states "I ain't do nothing." "The reporting form states that the physician was notified as well as Social Service. The "Additional Comments" noted on 12/3/09 by E2 state, "Seen by (Z5), NNO (no new orders), (no) further occurrences of this nature at this time." E2 confirmed on 3/4/10 that the last time R6 saw Z5 was in September. E1 and E2 signed the reporting form on 11/30/09 and 12/4/09. The Department was not notified.

The 9/17/09 progress note by Z5 did not address sexual behaviors. The note stated that R6 was very angry and "is not taking any of his medications." R6 walked out of the meeting with Z6 before it was finished. The note stated that R6 was showing a poor response to the medication because of "non compliant issues."

E16, Activity Aide, stated on 2/23/10 that he observed R6 fondling R7's breasts in the activity/dining room. E16 stated that he told R6 to stop and reported the incident to a nurse. E16 stated that he had seen R6 fondle the breasts of R8 also in the activity/dining room several months ago after the R7 incident. E16 stated he had written a statement about that incident too and gave it to E11, Activity Director. E16 stated that R6 is "smooth" and waits til no one is around and then does it to the residents that are confused. E16 stated that R6 is suppose to be monitored but there was no other staff around. E16 stated that R7 and R8 are confused and cannot fight for themselves.

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F9999	Continued From page 149 E11 stated on 2/23/10 that she had not seen R6 fondling any residents. E11 stated that there had been no allegations of R6 fondling R7 or R8 reported to her by the activity staff. E2 and E1 stated on 2/23/10 and 2/24/10 that they were not aware of any incidents with R6 and R8. E1 confirmed on 2/22/10 that there were no other incidents available for R6 except for the 11/21/09 incident. There are no social service notes for the 11/21/09 incident. R8 is assessed as moderately cognitively impaired with short and long term memory impairment on the 8/11/09 and 1/21/10 Minimum Data Set. R8 is ambulatory and has the behavior of wandering into others rooms was identified. The only incident report provided was for 10/24/09 when 3 scratches were observed on R8's back. The family felt there was some kind of "sexual activity" and requested a gynecological exam. The investigation states that it was concluded that the scratches were self inflicted and the exam was cancelled. R7 was also assessed as moderately cognitively impaired with short and long term memory problems. Neither R7 or R8 could answer any question when attempted. E2, Director of Nursing, stated on 2/24/09 that R6 was monitored closely and counseled twice about his sexual behavior. E2 stated that R6 was kept off the ladies hall and monitored. E2 stated she was not aware of the incident with R8. E2, Director of Nursing, stated on 2/23/10 that the only incident report for R6 was on 11/21/09. E2 confirmed that none of the incidents had been reported to the Department.	F9999		

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F9999	Continued From page 150 2. According to the medical record, R11 was readmitted to the facility on 1/25/10 with diagnoses, in part, of schizophrenia, personality disorder, anxiety and diabetes mellitus. R11 is 33 years old. R11 was started on Provera 5 milligrams every morning on 1/26/10. On 1/25/10 R11 was sent to the emergency room for "Increased sexually inappropriate behavior." E17, Corporate Nurse, confirmed on 3/4/10 that there was no care plan or Minimum Data Set (MDS) completed for R11. There are no nurses notes regarding inappropriate sexual behavior to other residents. E7, Certified Nurse Aide, stated on 2/23/10 that R11 is "inappropriate with all females." E7 stated that R11 would invade their space and touch, kiss and hug them. E7 stated that on Fat Tuesday (2/9/10) last week that he observed R11 had fondled the breast of R13. E7 stated that R13 was seated at the nurses station in her wheelchair and R11 put his hand down her shirt and fondled her breast. E7 stated that R13 started screaming but is not able to defend herself. E7 stated he reported it to E9, Licensed Nurse. E9 stated on 2/23/10 that E7 had reported that R11 had R13's shirt up and had fondled her breast. E9 stated that she had asked R11 what he was doing and he stated that R13 was his girlfriend and he could feel her breast. E9 stated that R13 would not be able to defend herself. E9 stated that she has seen him kiss R14 last Friday (2/19/10). E9 stated that she reported the incident to E10, Licensed Nurse, who was R11's nurse and was not sure if she had reported it. E10 stated on 2/24/10 that she was unaware of the allegations regarding R11 and R13. E2,	F9999		

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F9999	Continued From page 151 Director of Nursing, stated on 2/24/10 that she was unaware of the allegation regarding R11 fondling R13. There are no nurses notes or social service notes regarding the incident in R11's medical record. According to the medical record, R13 diagnoses, in part, includes aphasia, cerebral vascular accident, and confusional state. R13 was assessed on the 11/26/09 Minimum Data Set as severely cognitively impaired and requires extensive assistance of 1 person for transfer and bed mobility. R13 is dependent on staff for locomotion, dressing and toilet use. R13's main mode of locomotion is a wheelchair. R14 stated on 2/25/10 that one resident was bothering her, R11. R14 stated that R11 gave her a ring and kissed her several times. R14 stated she has not slept with him. R14 stated that "This isn't a whore house, it's a nursing home-they should tell him it's for rehab." R14 stated that R11 is "young" and "horney." The facility identified R14 as interviewable. Confidential resident interview stated on 3/2/10 that she has seen R11 touch R17 and kiss her. The interview also stated that R11 touched R17's breasts. The interview was identified as interviewable by the facility. R17 stated on 3/2/10 that R24 had rubbed her stomach and stated "You know what I want." 3. R9 was admitted to the facility on 10/7/09 under parole from a Federal Prison. His diagnoses include, in part, multiple concussions, seizure disorder, cocaine and alcohol abuse, antisocial personality disorder, and Hepatitis C. A "Criminal History Analysis" was done on	F9999		

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F9999	Continued From page 152 11/29/09 and R9 was identified as "High Risk." The Minimum Data Set dated 10/19/09 assessed R9 as moderately cognitively impaired with no short or long term memory problems. The "Psychology Consultation" from the Federal Prison dated 6/29/09 noted that the consult had been requested to aid in finding placement for R9 while he finished his 3 year supervised parole. The report states R9 attempted to scale a fence to escape from the facility. It also stated that he attempted to obtain sexual gratification on several occasions by entering the rooms of female peers. The "Recommendations" of the consult stated "Without his cooperation with psychological and neurocognitive testing, it is virtually impossible to provide meaningful recommendations. Providers need to be aware that (R9) feigns illness to manipulate care givers and custodial staff. He is ambulatory, but has significant bilateral gain ataxia (incoordination). It is unclear how much of his memory, judgement, and planning may have been affected by the past stroke. Likely, those functions were not affected greatly. Under any living arrangement, he will likely continue to present a management problem given his maladaptive personality style. He has no major mental illness, otherwise, that requires psychiatric intervention." The care plan dated 10/20/09 identifies under "Behavior Problem" "new admit from Fed. (Federal) Prison S/P incarceration for bank robbery 2 yrs. (years) on probation 3 yrs. (years). Hx (history): polysubstance abuse causing multiple arrests in the past. He can be restless at times, talks inappropriately about sex, note hand in his pants, left facility without permission, ER calling." The "Goals" listed on the care plan	F9999		

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F9999	Continued From page 153 states "(R9) will not carry out any consensual sexual activity without knowledge of S.W. (Social Worker)," Administrator;" "Will be informed when he is inappropriate w (with) any behavior;" and, "Be reminded he is on probation, his parole officer will be notified for any problems." Handwritten notes with no date to the care plan state, "Reports to having sex with another res. (resident), exposing self to visitor." The "Approaches/Interventions" listed include, in part, "If he is sexually inappropriate, immediately let him know his behavior is unacceptable," "Parole officer will be notified for any unacceptable behavior he is not willing to stop with warning," "If he has his hands in his pants around others, remind him, this is not acceptable, remove him to his room for privacy," "Report any behaviors to nurse, document, notify M.D. (Medical Doctor), S.W. (Social Worker), Parole Officer PRN (As Needed)," "Monitor his whereabouts several times hourly to ensure he is behaving appropriately." On 10/12/09 R9 left the facility without telling staff he was leaving. R9 went out his window around between 10:00 PM and 11:00 PM. The "Social Progress Notes" state that R9 "left out window because he needed/wanted to have sex with his friend. He went on to state that he was planning on coming back through the window when he was done, but he made her mad and she hit him with her van." The note also states that R9 was in violation of his parole due to leaving the facility without permission. The incident was not reported to the Department according to E1, Administrator, on 2/23/10. E1 stated that R9 did not receive an injury and due to the new Department rule she did not have to	F9999		

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F9999	Continued From page 154 report it. R9 received contusions to the hip and thigh according to the emergency room record dated 10/12/09. The "Social Progress Note" dated 10/26/09 stated that E5, Social Service Director, spoke with R9 regarding a "rumor" that he and a female resident were contemplating a sexual relationship. E5 wrote that both parties must be consenting, in a private place and with condoms. There was no documentation that E5 discussed the importance of condoms due to R9's Hepatitis C diagnosis. The "Social Progress Note" for R10 dated 10/26/09 noted that E5 discussed that both parties must be consenting, be in a private place and use condoms. There was no documentation regarding the risk of contracting Hepatitis C. The "Social Progress Note" dated 10/29/09 stated that E5 had received information from the treatment nurse that R9 and R10 had sexual relations in the activity room around 9:00 PM the night before. The note states that R9 stated R10 approached him and they attempted to have sex in the corner. No condoms were used. The note for R10 states that she denied the incident. There was no incident report as confirmed by E2 on 2/23/10. According to the medical record, R10 was admitted to the facility on 4/24/09 with diagnoses, in part, of cerebral vascular accident, expressive aphasia, left hemiparesis, dysphagia with a gastrostomy tube feeding, and vascular dementia with agitation. The Minimum Data Set (MDS) dated 8/6/09 assessed R10 as moderately cognitively impaired with short term memory	F9999		

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problems. The MDS noted that R10 could not stand without physical help from one person. R10's primary mode of transportation was a wheelchair. R10 was observed in a wheelchair during the survey.

On 11/2/09 the nurses notes state that the physician was contacted for an order for a Hepatitis C test due to R10's "possible sexual contact (with) someone known to be positive for Hep. C." The physician declined stating there was no medical diagnosis for this test.

E2 stated on 2/24/10 that they would try to keep R9 and R10 apart. E2 stated she had heard they were having sex in the activity room. E2 stated she felt R10 was seeking out R9 and they had found her in his room.

E5, Social Service Director, stated that she was aware R9 had Hepatitis C. E5 stated that she felt R9 and R10 were consenting parties and she had talked to them about using condoms. E5 stated that the behavior would occur in the evening when administrative staff was not here. E5 stated that she was aware of an instance of intercourse. E5 stated she talked to both about the incident and R9 admitted the occurrence but R10 denied it. E5 stated staff told her that R10 would pursue R9.

E7, Certified Nurse Aide, stated on 2/23/10 that he had been instructed to keep R9 and R10 apart by the Director of Nursing and the Administrator. E7 stated that R10 had been caught in R9's room, kissing and hugging.

E9, Licensed Nurse, stated on 2/23/10 that they would try to keep R9 and R10 apart. E9 stated

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F9999	Continued From page 156 that they would try to keep them at the nurses station and off the halls. E9 stated she did not recall anyone talking about using protection. On 11/15/09 R9 exposed himself to a visitor in the facility. The nurses notes states that a visitor was at the facility on the ladies hall visiting with two of the residents when R9 came down the hall in a wheelchair. The nurses notes state that the visitor was talking to R9 when he pulled his penis out of his pants to show it to her. The visitor left. There was no documentation regarding the two residents that witnessed R9 exposing himself. There was no incident report for the incident as confirmed by E2, Director of Nursing, on 2/24/10. On 11/18/09 R9 was observed by E24, Care Plan Nurse, to approach R10 twice. The notes states that a nursing meeting was held with the 3 PM to 11 PM staff and they indicated that they (R9 and R10) do not listen once the administrative staff leave. R9 was discharged on 11/25/09 to another long term care facility. Z10, Probation Officer, stated on 3/10/10 that R9 was discharged from the facility to another long term care facility because R9 was not following the rules at the facility. Z10 stated she was aware he had left the building, exposed himself to a visitor and had been having sexual relations with a female resident at the facility. Z10 stated she was not aware the female resident was negative for Hepatitis C and moderately cognitively impaired. Z10 stated she was not working when R9 was transferred to the other facility and had not talked to the new facility. Z10 stated that the two probation officers that took him to the new facility would not have known any background information regarding R9.	F9999		

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Z10 stated that the sister of R9 worked at the other facility and had talked to the supervisor about R9 and got him admitted there. Z10 stated she was not aware that R9 had attempted to rape an elderly resident at the new facility and that would be grounds to revoke his parole. Z10 stated the new facility had only told them he had lifted the skirt of a resident and was discharged from the new facility according to the documentation she had. Z10 stated that their region was monitoring R9 as a courtesy to another parole officer, Z11.

Z11, parole officer for R9, stated on 3/11/10 that he was not aware of all the allegations against R9. Z11 stated that if the nursing home would have called him they would have picked him up and found other placement. Z11 stated that if he had been made aware of the allegations at the second nursing home he would have revoked his parole and issued a warrant for R9's arrest. Z11 stated he had only been told he had lifted the skirt of a resident. Z11 stated that he was not called by either nursing home regarding R9. Z11 stated that if the nursing home would have filed a complaint with him or the police the incident at the second nursing home would not have happened. Z11 stated the state police were not aware of the incidents.

According to the nurses notes dated 11/25/09 R9 was discharged to another long term care facility on 11/25/09. The note states "2 Probation Officers came to facility to transport resident to (long term care facility)." The Department was not notified that R9 was transferred to another long term care until 12/3/09. E1, Administrator, confirmed on 2/23/10 that the Department was not notified of any of the incidents regarding R9's

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F9999	Continued From page 158 inappropriate sexual behavior or elopement. 4. According to the medical record, R14 was admitted to the facility on 12/10/09 with diagnoses, in part, of Psychosis, schizophrenia and diabetes. R14 was assessed on the 12/22/09 MDS as modified independence for cognition with no short or long term memory problems. The facility identified R14 as interviewable. The care plan dated 12/23/09 does not identify any sexual behavior or abuse problems. The care plan for "Mood State" identified that R14 was alert and oriented times 3 and "makes reasonable decisions." It states that R14 was "unhappy, uncooperative several days after admit, seems to be adjusting." The care plan also notes as a behavior that R14 changes her clothes several times during the day and night. R14 stated on 2/25/10 that the only resident bothering her was R11. R14 stated that R11 gave her a ring and kissed her several times. R14 stated that she was doing much better than when she was first admitted to the facility. On 12/10/00 at 5:00 PM the nurses notes by E9, Licensed Nurse, documented that on admission R14 stated that R15 "tried to rape her and she would knock him out and his teeth. Very argumentative with staff and her peers. Approach resident carefully. Resident became very hostile, Nurse staff and CNA (Certified Nurse Aide) attempting to hit (with) fist clenched." The physician was called and ordered Haldol 5 mg/Ativan 2 mg intramuscularly now. E2 stated on 2/25/10 that she was not aware of	F9999		

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F9999	Continued From page 159 the allegation of rape made by R14. E2 stated that there had been no investigation into the allegation. E5, Social Service Director, stated that she was not aware of the allegation. E9 stated on 3/10/10 that R14 had made that statement when she was first admitted. E9 stated that R14's daughter was there and did not think it had happened. E9 stated that she had called the physician for the Haldol order but was not sure she had told him regarding the rape allegations. E9 stated she had called the physician for the Haldol because R14 was so upset and wanted to leave. E9 stated she could not remember if the physician had been told about the rape allegations. (A) 300.1630a)1)2)3) 300.1630b) 300.1630c) 300.1630e) Section 300.1630 Administration of Medication a) All medications shall be administered only by personnel who are licensed to administer medications, in accordance with their respective licensing requirements. Licensed practical nurses shall have successfully completed a course in pharmacology or have at least one year's full-time supervised experience in administering medications in a health care setting if their duties include administering medications to residents. 1) Medications shall be administered as soon as	F9999		

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F9999	Continued From page 160 possible after doses are prepared at the facility and shall be administered by the same person who prepared the doses for administration, except under single unit dose packaged distribution systems. 2) Each dose administered shall be properly recorded in the clinical record by the person who administered the dose. (See Section 300.1810.) 3) Self-administration of medication shall be permitted only upon the written order of the licensed prescriber. b) The facility shall have medication records that shall be used and checked against the licensed prescriber's orders to assure proper administration of medicine to each resident. Medication records shall include or be accompanied by recent photographs or other means of easy, accurate resident identification. Medication records shall contain the resident's name, diagnoses, known allergies, current medications, dosages, directions for use, and, if available, a history of prescription and non-prescription medications taken by the resident during the 30 days prior to admission to the facility. c) Medications prescribed for one resident shall not be administered to another resident. e) Medication errors and drug reactions shall be immediately reported to the resident's physician, licensed prescriber if other than a physician, the consulting pharmacist and the dispensing pharmacist (if the consulting pharmacist and dispensing pharmacist are not associated with the same pharmacy). An entry shall be made in the resident's clinical record, and the error or reaction shall also be described in an incident	F9999		

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F9999	Continued From page 161 report. These regulations were not met as evidenced by: Based on interview and record review the facility failed to ensure medications were administered as ordered and in a timely manner, failed to administer medications to the correct resident, and administered the wrong medication, resulting in four significant medication errors for 3 (R12, R18, R21) of 3 residents reviewed for medication errors. The findings include: 1. R18's Interdisciplinary Progress Notes (Nurse Notes), dated 2/7/10, 5:00 PM indicates R18 was in his wheelchair waiting for dinner, with his eyes closed. At 5:35 PM, he could not hold his sandwich and did not respond verbally. E10 documented his respirations were even and unlabored, with no shortness of breath and no other distress, and she would continue to monitor. At 6:00 PM his blood pressure was 90/50, his skin was pale in color and R18 remained unresponsive. E10 called Z2, Physician Assistant (PA) and received orders to send R18 to the emergency room for evaluation. She did not call 911, she called the ambulance company direct and they told her it would be about 30 minutes before they would be there. At 6:25 PM R18 remained in his room unresponsive and E10 tested his blood glucose. The reading was "high" three times. According to the manufacturer's specifications when the device reads "high" it is indicating the blood sugar level is over 550 (normal 65-99 mg/dL). The Nurse Notes indicate that, at that time E10 called Z2 back and he gave an order for GlucaGen 1 mg	F9999		

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F9999	Continued From page 162 (milligram) IM (intramuscular) now. According to Lexi-Comp's Drug Information Handbook for Nursing, 2009, GlucaGen is a trade name for Glucagon. Glucagon is used to manage hypoglycemia or low blood sugar. According to Stedman's Medical Dictionary, 24 th Edition, the definition for Hypoglycemia is an abnormal small concentration of glucose in the circulating blood, reduction in blood glucose (low blood sugar). R18's blood sugar was elevated indicating he was hyperglycemic. Hyperglycemia is an abnormally high concentration of glucose in the circulating blood. At 6:50 PM the ambulance arrived to transport R18 to the hospital. On 3/1/10, at 3:30 PM, in the facility conference room, E10 verified the information in the Interdisciplinary Progress Notes. E10 went on to say that even though R18 was not a diabetic she decided to check his blood glucose and had not thought to check it at 5:00 or 6:00 PM. She stated R18 is blind and he closes his eyes a lot and since his hearing is impaired he usually yells. She said after she checked R18's blood sugar level, she called Z2 back and he said to give 1mg Glucagon IM. She said she had never heard of that medication and did know what is was for. She said she tried to look it up and could not find it, so she went to the medication room to the emergency box and looked for the medication that sounded like what Z2 had ordered. She said there was no Glucagon in the emergency box but she knew that a resident on F Hall had some so she got his out of the cart and gave it to R18. She also said that now she knows that Glucagon is the not same as Glucophage so she would not make that mistake again. Glucagon increases blood sugar and Glucophage decreases blood sugar levels.	F9999		

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F9999	Continued From page 163 Lexi-Comp's Drug Handbook for Nursing 2009 indicates that Glucophage is a brand name for Metformin which is an antidiabetic agent and used to manage type 2 diabetes mellitus (noninsulin dependent). E10 indicated that she "got wrote up" on 2/24/10 after the "state" came in. On 2/25/10 at 3:15 PM, in an interview by telephone, Z2 stated that when he gives an order for a patient to be sent out to the emergency room, he means that 911 should be called. He also said that E10 did not call him a second time, and he would have never given an order for Glucagon, which is used for hypoglycemia, not hyperglycemia. On 2/24/10 E2, Director of Nursing, stated that when she heard about the GlucaGen being given to R18 she asked E10 what happened, but she did not fill out an incident report, initiate an investigation; or inservice E10 . She said the only thing she did was tell E1, the administrator. Emergency Room records dated 2/7/10, at 1930 (7:30 PM) show R18's blood glucose was 927 and Acetone positive, and he was treated with IV insulin which was discontinued 2/8/10 at 5:00 AM. He was then admitted to the hospital with diagnoses: Hyperglycemia, COPD Exacerbation, Dehydration and Renal Insufficiency. 2. According to the Resident Face Sheet, R21 was admitted to the facility on 2/12/10 with diagnoses which included Psychosis, Paranoid Schizophrenia, Seizure Disorder, Personality Disorder, Parkinsons Disease and	F9999		

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F9999	Continued From page 164 Gastroesophageal Reflux Disease. On the Physician's Order Sheet (POS), the physician ordered nursing staff to administer the following medications: a) Aspirin (ASA) 325 milligrams (mg) daily, b) Trihexyphenidyl 5 mg. twice daily, c) Haldol 10 mg three times daily, d) Invega 6 mg. every a.m., e) Calcium 250 mg. and Vitamin D daily, f) Sinemet 25/250 mg. three times daily, g) Depakote ER (Extended Release) 750 mg. daily, h) Folic Acid 1 mg. daily, i) Keppra 500 mg. three times daily, j) Multivitamin daily, k) Nystatin 100,000 Suspension 5 cubic centimeters (cc) daily, and l) Trazodone 50 mg. at bedtime. In addition the physician ordered the following medications to be given on an as needed basis: aa) Milk of Magnesia 30 cc., bb)Maalox Plus suspension 30 cc., cc)Lorazepam 1 mg. tablet every four hours as needed, dd) Lorazepam 1 mg. IM (Intramuscular) every four hours as needed, ee) Ibuprofen 600 mg. three times daily as needed and ff) Haldol 5 mg. IM every four hours as needed and gg) Loperamide 2 mg. Review of the February 2010 Medication Administration Records showed that R21 did not receive any medications on 2/12/10, 2/13/10 and until 2/14/10 at 9:00 a.m. There are no entries about not administering the routine medications as ordered made by nursing in the Interdisciplinary Progress Notes. Nursing staff did chart R21 was experiencing anxiety, hyperactive talking, wandering about on the admission note 2/12/10. On 2/12/10 and 2/13/10 nursing charted that R21 was up and walking around from 2:15 a.m. until 10:45 p.m. and was having auditory and visual hallucinations. Review of the Medication Administration Record failed to show that nursing staff administered either Lorazepam or Haldol that were ordered on	F9999		

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F9999	Continued From page 165 an as needed basis to control the combative and anxious behaviors. Until these errors of omission were brought to the attention of E2, Director of Nursing (DON), the facility was unaware that R21 did not receive medications from 2/12/10 until 2/14/10. Telephone interview with E2, Director of Nurses (DON) showed that R21's medications were ordered STAT on 2/13/10 and were received at the facility at 11:37 a.m. that same day. E2 said that she was not aware that the medications were not started until 2/14/10 at 9:00 am. and why the Physician was not notified. 3. Review of a Medication Error Report dated 2/17/10 showed that E25, Licensed Practical Nurse (LPN) administered R26's 9:00 a.m. medications to R12. Interview with E25 on 3/1/10 at 4:55 p.m. showed she was passing morning medications when E5, Social Service Designee (SSD) started talking to her about what to chart on the Medication Administration Records (MAR). R12 stated that E5 flipped up a page on the MAR before leaving. E25 stated she had just finished preparing medication for R26, however, she entered R12's room by mistake. E25 stated that R26 and R12 both took medication through the gastrostomy tube. She stated the medications were liquid and crushed for the G-tube prior to administration. E25 said as soon as she came out of R12's room and looked at the MAR, she realized the error. E25 said she had only been at the facility for a few days and was also a new LPN at her first job. E25 stated E26, LPN who was orienting her was at the nurses' desk when the error occurred.	F9999		

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F9999	Continued From page 166 Review of the Medication Administration Record for R26 shows that he was to receive Docusate Sodium, Folic Acid, Multivitamin Liquid, Thiamine, Ferrous Sulfate Elixir, Keppra Solution, Nexium, and Senna Syrup. E25 documented that the above medications were given to E12 in the Interdisciplinary Progress Notes on 2/17/10 at 11:45 a.m. However, on the Medication Error Report dated 2/17/10, E25 wrote that Iron, Thiamine, Multivitamin (MVI), Folic Acid and Colace were the medications given in error. It does not show that Nexium, Keppra, and Senna Syrup were also given in error. This form was signed by E25 and E2, the Director of Nursing (DON). On the Medication Error Report it is documented that R12 was to receive a 200 cubic centimeter (cc) flush at 9:00 a.m. On the Cumulative Diagnosis sheet, R12 has diagnoses which include Stroke, Altered Mental Status, Amputation left Big Toe, Hypertension, Hyperlipidemia, and Mild arteriosclerotic occlusive disease (bilateral extremities). E2 produced one page of an Orientation Packet given to new nurses, the "Medication Administration Orientation Program." When questioned on 3/2/10 at 2:30 p.m., E2 stated there was not one completed for E25 and she did not have any other documentation to validate that any of the Orientation was completed. When interviewed on 3/1/10 at 4:55 p.m., E25 was on duty as an LPN. During a telephone interview at 2:25 p.m. on 3/9/10, E2, DON confirmed that none of these medication errors were reported to the Department. 4. According to an entry in the Interdisciplinary	F9999		

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F9999	Continued From page 167 Notes, R12 was admitted to the facility on 2/15/10 at 8:00 p.m. Upon admission, the Physician ordered nursing staff to administer Famotidine, Zanaflex, Ritalin, Keppra, Colace Liquid, Lopressor, Potassium Chloride, Dantrium, Ceftin, Motrin. A 200 cc water flush was to be administered every four hours. On the Cumulative Diagnosis sheet, R12 has diagnoses which include Stroke with right side hemiplegia, Transient Ischemic Attack, Altered Mental Status, Amputation left Big Toe, Hypertension, Hyperlipidemia, and Mild arteriosclerotic occlusive disease (bilateral extremitiestry). On 2/15/10 at 8:00 p.m. in the Progress notes it states, "Unable to fax POS at this time. will continue to try." On 2/15/10 at 10:00 p.m. the nurse wrote, "Tried to fax POS to pharmacy and still unable to fax will try again." There are no further notes which address additional attempts to obtain R12's medication. Review of the February 2010 Medication Administration Record (MAR), nurses have circled their initials to indicate R12 did not receive a medication as ordered or left the areas blank indicating that R12 did not receive medications on the evening of 2/15/10, and on the next three days of the 2/16/10, 2/17/10, and 2/18/10. The medications listed as not being given on these days were Famotidine 20 mg. every 12 hours, Zanaflex 2 mg. three times daily, Keppra 250 mg. daily, Colace liquid 50 mg. twice daily, Lopressor 25 mg. twice daily, Potassium Chloride 10 % 20 meq. (milliequivalents), and Dantrium 25 mg. daily. The medication Ritalin 10 mg. twice daily was marked on the MAR "Pharmacy called...until 2/19/10 to send meds per (Gastrostomy) G-tube. On 2/15/10 the Physician also ordered the antibiotic Ceftin 250 mg. to be given for five days.	F9999		

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F9999	Continued From page 168 Nursing had marked the 5 day time span beginning 2/16/10 through 2/20/10 where they wrote "STOP." According to the MAR the first dose was not given until 2/18/10 at 6 p.m. and then nursing staff administered the medication on 2/19/10 and 2/20/10 stopping it after the 6 p.m. dose on the 20th. The nurses initialed that R12 received a total of 4 doses during the five day period. According to the POS R12 should have received 10 doses during that same five day period. On the POS an entry dated 2/19/10 documentats the Physician reordering the antibiotic Ceftin 250 mg. for 10 days. In the Physician Progress Notes on 2/17/10 is written, "Patient returned to facility 2/15 (after) being hospitalized with Sepsis and Pneumonia. He was on a ventilator. Received IV (intravenous) ABT (antibiotic treatment). He continues to be on Ceftin and Oxygen." "Lungs a few crackles on right. Cerebral Vascular Accident, Pneumonia, Sepsis. Continue current regimen." Review of the February 2010 MAR showed that R12 did not receive the first dose of the medication until 2/22/10 at 6 a.m. On 2/23/10 the Physician ordered staff to "Send patient (R12) to Memorial Hospital for Evaluation." According to the History and Physical at the Hospital, the Physician diagnosed R12 as having acute respiratory failure secondary to chronic aspiration, and Aspiration Pneumonia. Telephone interview with E2, Director Of Nursing (DON) at 2:40 p.m. showed that E2 was unaware of the delay in starting the medications and would be doing an investigation to find out why the meds were not ordered when the resident came	F9999		

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F9999	Continued From page 169 in as a new admission and why the Physician was not notified. E2 also stated that the nurses wrote the following information on the back of the MAR: on 2/16/10- meds not available, 2/20/10 Colace need clarification, 2/20/10 Ceftin needed clarification as the rationale for why the medications were not given. Other initials circled to indicate that the medications were not given did not have any explanation on the back of the MAR as required by facility policy. 5. The Ordering of Medications policy directs staff to "Refer to "Resident Admission" to complete physician's medication orders. The Resident Admission policy requires staff to complete the Admission Order sheet and to enter medication orders and treatment orders. If the medication orders are incomplete, call the physician. Fax completed Admission Sheet orders to pharmacy. The policy also states, "If the admission occurs after the pharmacy is closed, the nurse should utilize the pharmacy emergency telephone paging system." 6. The facility Medication Administration Policy requires nursing staff to administer medications in accordance with "the 6 R's" : the right resident, the right drug, the right dose, the right dosage form, the right time, and the right route. The resident's medication administration record is initialed by the person administering the medication in the space provided under the date and on the line for that specific medication dose administration. The policy directs "nursing staff shall document any medications held or refused by circling their initials and document on the back of the medications administration record. Include the date, time medication, dose, reason for	F9999		

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F9999	Continued From page 170 omission and initials. (A) 300.625f) 300.625g)1) 300.625l) 300.625o) 300.626c) 300.627e) Section 300.625 Identified Offenders f) If the results of a resident's criminal history background check reveal that the resident is an identified offender as defined in Section 1-114.01 of the Act, the facility shall immediately fax the resident's name and criminal history information to the Department. (Section 2-201.5(c) of the Act) g) If identified offenders are residents of a facility, the facility shall comply with all of the following requirements: 1) The facility shall inform the appropriate county and local law enforcement offices of the identity of identified offenders who are registered sex offenders or are serving a term of parole, mandatory supervised release or probation for a felony offense who are residents of the facility. If a resident of a licensed facility is an identified offender, any federal, State, or local law enforcement officer or county probation officer shall be permitted reasonable access to the individual resident to verify compliance with the requirements of the Sex Offender Registration	F9999		

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F9999	Continued From page 171 Act, to verify compliance with the requirements of Public Act 94-163 and Public Act 94-752, or to verify compliance with applicable terms of probation, parole, or mandatory supervised release. (Section 2-110(a-5) of the Act) Reasonable access under this provision shall not interfere with the identified offender's medical or psychiatric care. l) The facility shall incorporate the Criminal History Analysis Report into the identified offender's care plan. (Section 2-201.6(f) of the Act) o) The facility shall evaluate care plans at least quarterly for identified offenders for appropriateness and effectiveness of the portions specific to the identified offense and must document such review. The facility shall modify the care plan if necessary in response to this evaluation. The facility remains responsible for continuously evaluating the identified offender and for making any changes in the care plan that are necessary to ensure the safety of residents. Section 300.626 Discharge Planning for Identified Offenders c) When a resident who is an identified offender is discharged, the discharging facility shall notify the Department. Section 300.627 Transfer of an Identified Offender e) If the following information has been provided to the transferring facility from the Department of Corrections, the transferring facility shall provide copies to the receiving facility before making the	F9999		

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F9999	Continued From page 172 transfer: 1) The mittimus and any pre-sentence investigation reports; 2) The social evaluation prepared pursuant to Section 3-8-2 of the Unified Code of Corrections [730 ILCS 5/3-8-2]; 3) Any pre-release evaluation conducted pursuant to subsection (j) of Section 3-6-2 of the Unified Code of Corrections [730 ILCS 5/3-6-2]; 4) Reports of disciplinary infractions and dispositions; 5) Any parole plan, including orders issued by the Illinois Prisoner Review Board and any violation reports and dispositions; and 6) The name and contact information for the assigned parole agent and parole supervisor. (Section 3-14-1 of the Unified Code of Corrections) These regulations were not met as evidenced by: Based on observation, interview and record review the facility failed to notify the Department immediately of admission of Identified Offenders and of Identified Sex Offender; the facility failed to assess the risk factors and supervision required for each resident, and failed to develop an individualized Care Plan with quarterly reviews which address the effectiveness for the identified offense for 4 of 8 residents (R5, R9, R19, R6). And the facility failed to address serious behavior issues for 1 of 3 residents on the discharge summary and provide complete information to another Long Term Care facility (R9). The findings include: 1. R5 was admitted to the facility on 12/24/09	F9999		

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F9999	Continued From page 173 and is an Identified Sex Offender (IO) . Record review showed the facility did not notify the Department until 2/12/10. When questioned, E1, Administrator stated that the facility did not notify the local law enforcement for R9. Record review showed the facility had not conducted any assessment regarding risk factors and supervision required for any of the 8 in-house Identified Offenders. Review of the Care Plans failed to document 8 Identified Offenders Status with specific approaches for staff to implement. This was confirmed with E1, Administrator and E5, Social Service Designee (SSD) 3/9/10 during interview. E5 stated that the Care Plans have never contained information about Identified Offenders in order to protect their privacy. The facility provided a list of Identified Offenders on 3/9/10 which showed that there are currently 8 identified offenders residing at the facility. The facility policy for "Identified Offenders" requires "Within 14 days following the verification that a resident is an "identified offender" the facility will conduct a violence risk assessment. The facility care plan team will develop an individual care plan/treatment plan for all identified "Offenders" residing in the facility. Care plans will be reviewed quarterly and modified if needed." The policy also requires that the facility will notify the Department within 48 hours that an Identified Offender is residing in the facility. 2. R2 was admitted to the facility on 12/24/09 and is an Identified Sex Offender (IO). Record review showed the facility had not conducted any assessment regarding risk factors and supervision required. Review of the Care Plan failed to document R2's Identified Offender Status with specific approaches for staff to	F9999		

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F9999	Continued From page 174	F9999		

implement. This was confirmed with E1, Administrator and E5, Social Service Designee (SSD)3/9/10 during interview. E2 stated that the Care Plans have never contained information about Identified Offenders in order to protect their privacy.

3. R9 was admitted to the facility on 10/7/09 under parole from a Federal Prison. His diagnoses include, in part, multiple concussions, seizure disorder, cocaine and alcohol abuse, antisocial personality disorder, and Hepatitis C. A "Criminal History Analysis" was done on 11/29/09 and R9 was identified as "High Risk." The Minimum Data Set dated 10/19/09 assessed R9 as moderately cognitively impaired with no short or long term memory problems.

The "Psychology Consultation" from the Federal Prison dated 6/29/09 noted that the consult had been requested to aid in finding placement for R6 while he finished his 3 year supervised parole. The "Recommendations" of the consult stated "Without his cooperation with psychological and neurocognitive testing, it is virtually impossible to provide meaningful recommendations. Providers need to be aware that (R9) feigns illness to manipulate care givers and custodial staff. He is ambulatory, but has significant bilateral gain ataxia (incoordination). It is unclear how much of his memory, judgement, and planning may have been affected by the past stroke. Likely, those functions were not affected greatly. Under any living arrangement, he will likely continue to present a management problem given his maladaptive personality style. He has no major mental illness, otherwise, that requires psychiatric intervention." The report also stated that R9 "inappropriately attempted to obtain

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F9999	Continued From page 175 sexual gratification on several occasions while in the facility, by entering the rooms of female peers". The care plan dated 10/20/09 identifies under "Behavior Problem" "new admit from Fed. (Federal) Prison S/P incarceration for bank robbery 2 yrs. (years) on probation 3 yrs. (years). Hx (history): polysubstance abuse causing multiple arrests in the past. He can be restless at times, talks inappropriately about sex, note hand in his pants, left facility without permission, ER calling." The "Goals" listed on the care plan states "(R6) will not carry out any consentual sexual activity without knowledge of S.W. (Social Worker)", Administrator"; "Will be informed when he is inappropriate w (with) any behavior"; and, "Be reminded he is on probation, his parole officer will be notified for any problems". Handwritten notes with no date to the care plan states "Reports to having sex with another res. (resident), exposing self to visitor". The "Social Progress Note" dated 10/29/09 R9 was found having intercourse with a moderately cognitively impaired resident in the activity room. According to the "Social Progress Note" dated R9 also left the facility without staff knowledge on 10/13/09 to have sex. The "Social Progress Note" dated 11/9/09 states that an attempt was made to contact R9's parole officer due to residents behavior. Review of the nurses notes dated 11/13/09 by E2, Director of Nursing, stated "Conferred with (Z8, Probation Officer) (State) Probation and parole dt (due to) residents noncompliant, disrespectful behavior, elopement. SS (Social Service) and Administrator attending also. States dt (due to)	F9999		

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F9999	Continued From page 176 these behaviors most likely will have to be discharged back to the (City, State) penal system. Call placed to (Z9) at this time to make aware." E1, Administrator, stated on 2/23/09 that she was not sure if the information regarding R9's background and behavior was sent to the long term care facility he was sent to. E1 stated that they should have known he was a parolee because he went with his parole officer to the new facility. E1 stated that they had never had a parolee before. E1 stated that R9's sister worked at the other facility so she should have told them. E2 stated on 2/24/10 that R9 wanted to go to the other long term care facility because he was not happy here. E2 stated R9 said he could not do what he wanted to at the facility. E2 stated that the discharge was sudden and she did not talk to anyone at the other facility. E2 stated she was not aware of the requirements for an identified offender or parolee and what they were suppose to do. E5, Social Service Director, stated on 2/24/10 that R9 was discharged from the facility due to his behavior that they could not tolerate. E5 stated that she had talked to the parole officer about discharging and she had said it may take a week and he may have to go to a half-way house. E5 stated that R9's sister worked at the long term care facility he was transferred to and she gave them the information regarding R9. E5 stated that she did send the new facility the same information the jail system had given them. E5 stated the sister told the new facility why we were discharging R9 due to sexual problems and cigarettes. E5 stated that she only filled out the	F9999		

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F9999	Continued From page 177 "Post-Discharge Plan of Care" and it did not ask anything about behaviors. E5 stated she did talk to a staff at the other long term care facility about his behavior but could not recall who she talked to. E5 stated she faxed all the information to the new facility. Review of the "Post-Discharge Plan of Care" dated 11/25/09 does not identify that R9 is an identified offender. There is no information provided on the discharge summary regarding R9's sexually inappropriate behavior nor the elopement. Z10, Probation Officer, stated on 3/10/10 that R9 was discharged from the facility to another long term care facility because R9 was not following the rules at the facility. Z10 stated she was aware he had left the building, exposed himself to a visitor and had been having sexual relations with a female resident at the facility. Z10 stated she was not aware the female resident was negative for Hepatitis C and moderately cognitively impaired. Z10 stated she was not working when R9 was transferred to the other facility and had not talked to the new facility. Z10 stated that the two probation officers that took him to the new facility would not have known any background information regarding R9. Z10 stated that the sister of R9 worked at the other facility and had talked to the supervisor about R9 and got him admitted there. Z10 stated she was not aware that R9 had attempted to rape an elderly resident at the new facility and that would be grounds to revoke his parole. Z10 stated the new facility had only told them he had lifted the skirt of a resident and was discharged from the new facility according to the documentation she had. Z10 stated that their region was monitoring	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145705	A. BUILDING _____ B. WING _____	C 03/18/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIRGIL CALVERT N & REHAB CTR	**5050 SUMMIT AVENUE EAST SAINT LOUIS, IL 62205**

(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 178 R9 as a courtesy to another parole officer, Z11. Z11, parole officer for R9, stated on 3/11/10 that he was not aware of all the allegation against R9. Z11 stated that if the first nursing home would have called him they would have picked him up and found other placement. Z11 stated that if he had been made aware of the allegations at the second nursing home he would have revoked his parole and issued a warrant for R9's arrest. Z11 stated he had only been told he had lifted the skirt of a resident. Z11 stated that he was not called by either nursing home regarding R9. Z11 stated that if the first nursing home had filed a complaint with him or the police the incident at the second nursing home would not have happened. Z11 stated the state police were not aware of the incidents. According to the nurses notes dated 11/25/09 R9 was discharged to another long term care facility on 11/25/09. The note states "2 Probation Officers came to facility to transport resident to (long term care facility)." The Department was not notified that R9 was transferred to another long term care until 12/3/09. The Department was not notified of any of the incidents regarding R9's inappropriate sexual behavior or elopement as confirmed by E1 on 2/23/10. The facility did not notify the Department of R9's transfer to another long term care facility until 12/3/09. E5 provided a copy of the "Identified Offender Information Form" sent to the Department. The Criminal backround check was not attached to the form. 4. R19 was admitted to the facility on 2/15/08 with diagnoses, in part, of schizophrenia, alcohol	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIRGIL CALVERT N & REHAB CTR	**5050 SUMMIT AVENUE EAST SAINT LOUIS, IL 62205**

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F9999	Continued From page 179 abuse, inhalent abuse, headache, and peptic ulcer disease. R19 is 46 years old. The Minimum Data Set dated 12/23/09 assessed R19 as moderately cognitively impaired. R19 was identified as an offender and was assessed as a moderate risk on the "Criminal History Analysis" dated 3/18/08. Review of the care plan dated 12/24/09 stated under "Behavior Problems" that R19 "exhibited assaultive behaviors toward staff and peers. Had a bag of marijuana in his rm.(room)., became violent throwing over med carts, etc. Both staff and peers in danger of becoming hurt. 10/31/09 missing, returned thru window w (with) ETOH (alcohol) and odor of ETOH. Sent to hosp. both times." The care plan does not address the identified offender status of R19. The nurses notes of 10/31/09 at 7:10 PM documented that R19 was not in the building after a search of the building. Staff searched the building but were unable to locate R19. R19 was observed walking out of another residents room at approximately 7:30 AM. The nurse smelled alcohol on R19 and a bottle of alcohol was found in his room. R19 had left the facility through the window of R9. R19 was sent out for an evaluation and returned the next day. The Department was not notified of the incident. (B)	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F9999	Continued From page 180 .	F9999		