STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145517	A. BUILDING _____ B. WING _____	C 11/30/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEFFERSONIAN CARE CENTER	**1700 WHITE STREET MOUNT VERNON, IL 62864**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
F 332	Continued From page 21 a Percocet 5-325mg. at 11:25AM. R-7 did not have any food when the medication was given and the current physician order is for the medication to be taken with food. On 11-22-05 at 11:20AM. E-15(RN) gave the same medication, again without food being present. 2. On 11-21-05 at 11:30AM. E-8 delivered Prednisone 20mg. to R-5 without food. The current physicians order for the Prednisone states to give the medication with food. R-5 did not get his noon meal until 12:15PM. 3. Per observation on 11-22-05 R-8 received an Ost/Cal 500mg. at 11:13AM. delivered by E-15. R-15 had not received her noon meal when the medication was delivered. The current physicians order for the Ost/Cal 500mg. is to give the medication with food. All of the observed medication errors were discussed with E-1 and E-2 during the daily status meetings on 11-21 and 11-22.	F 332		
F9999	FINAL OBSERVATIONS Licensure Violations 300.1210a) 300.1210b)4 300.3240a) Section 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	F9999		

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F9999	Continued From page 22 practicable physical, mental, and psychological 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. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 4) Personal care shall be provided on a 24-hour, seven day a week basis. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. Based on written statements, interviews and record review, the facility failed to assure that 1 of 1 male residents reviewed was free from sexual abuse by a staff member. The abuse occurred on 11-07-05 at approximately 3:15 PM., while 2 certified nurse aids provided incontinent care to R-2. One CNA fondled R-2's penis while the other CNA looked to see if Z-2 was noticing what was happening. Findings Include: 1. Per Interview with E-4 Certified Nursing Assistant (CNA) on 11-14-05 at 3:15 PM., an incident occurred at approximately 3:15 PM., on 11-07-05. E-4 was working with E-5 (CNA). Both staff members were in R-2's room to clean	F9999		

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F9999	Continued From page 23 R-2 because he had been incontinent of urine. Per interview with E-4, E-5 did not attempt to wash R-2, but did start applying a barrier type ointment with her gloved hand to R-2's penis. E-4 stated R-2 has a penile implant that keeps his penis in a semi erect state at all times. Per E-4, E-5 was stroking R-2's penis up and down and then used her hand to pull down the foreskin and stroke the head of R-2's penis. Per E-4, Z-2 was sitting on the couch behind her and E-4 kept looking over her shoulder to see if Z-2 was watching what E-5 was doing. E-4 said that Z-2 was very upset at that time because Hospice nurses had told her that R-2 probably did not have long to live. Z-2 had been crying and was not paying close attention to E-5. E-4 said E-5's actions were too much for her to watch any longer because of the amount of time she was stroking R-2's penis. E-4 told E-5 " that is enough, we need to turn R-2 over." Per E-4, E-5 continued for a few more strokes then she helped E-4 turn R-2 to his right side. E-4 said that R-2 had a full erection by then and E-5 got more ointment and started to massage R-2's scrotum. E-4 said that E-5 did not apply the ointment to the buttocks as it was supposed to be used. Per E-4 the care took much longer than it should have if E -5 had just been cleaning R-2. E-4 stated to the surveyor on 11-14-05 " I think she was trying to jack him off!" E-4 said that after she left the room she "was in shock!' and told E-6 (CNA) what she had observed but did not tell any of the supervisors what she had seen. E-4 had to leave the facility soon after the incident because she was sick and had been having stomach pain all afternoon. E-5 was the only CNA left on duty for the East wing to give care to the residents for the remainder of the shift.	F9999		

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F9999	Continued From page 24 Per interview with E-6 on 11-23-05, at approximately 2:30 PM., verification was given that E-4 had told her about what she saw E-5 doing to R-2 and indicated that she (E-4) thought it was abusive. E-6 also verified that she had not reported what E-5 told her because she had not witnessed the incident and did not want to start anything. E-6 said that after E-4 had left the facility, both she and E-5 were outside taking a break. Per E-6, E-5 acted frustrated because she could not get an answer to the phone call she was trying to make. E-6 said she asked E-5 if everything was OK and E-5 responded that she was trying to call her boyfriend, and she wanted to tell him that she wanted him to "f*** her brains out" when she got home. Per E-6, she was so shocked by the statement that she did not ask any more questions. Per interview with Z-2 on 11-14-05 at 2:00 PM, Z-2 had been in the room during the incident and had thought that it had took a long time for E-5 to complete the peri-care. Z-2 was very upset about R-2's declining physical condition and was crying so hard that she was not observant on 11-07-05 at 3:15 PM during personal care by E-4 and E-5. Per Z-2 the concern stayed with her all night because she did not think E-5's actions during the care were entirely appropriate, especially the way she handled R-2's penis during the care. Z-2 said that she voiced her concerns to E-1 at approximately 7:30 AM on the 8th of November. Z-2 said that she was not positive at that time of everything that had occurred during the delivery of incontinent care. Per Z-2, when E-4 came on duty the afternoon of the 8th she asked E-4 if she could tell her what had happened to R-2 the	F9999		

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F9999	Continued From page 25 night before when E-5 had been in the room with her. Per Z-2, E-4 did tell her in specific terms what she had observed E-5 doing. Z-2 then asked E-4 if she would tell E-2 what had happened. E-4 agreed to talk with E-2 about the incident. Per interview with E-1 on 11-14-05, the facility had scheduled a family group meeting on the night of 11-08-05 at 6:00 PM. with the local Ombudsman. Per E-1, Z-2 attended the meeting and told the Ombudsman of what had happened the night before. E-1 said that the Ombudsman said that the actions described could be perceived as rape and the administrator should be notified immediately. E-1 was called and returned to the facility. Per E-1 the investigation was started at that time. Per review of a quarterly Minimum Data Set completed on 10-03-05, R-2 has severe cognitive loss and is dependent on staff for all of his personal and daily needs.	F9999		