STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145371	A. BUILDING _____ B. WING _____	C 10/22/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTA CARE CENTER OF BLOOMINGTN	**1509 NORTH CALHOUN STREET BLOOMINGTON, IL 61701**

(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 6 LICENSURE VIOLATIONS LICENSURE VIOLATIONS 300.610a) 300.1210a) 300.1220b)2) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. 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 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. Section 300.1220 Supervision of Nursing	F9999		

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F9999	Continued From page 7 Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. These regulations are not met, as evidenced by the following: Based on observation, interview, and record review the facility failed to protect R1 from being sexually abused. R1 is one of three residents sampled for abuse. The facility admitted a male sexual offender (R2) with knowledge the sexual offender had a recent history of sexual abuse at a sister facility. The facility failed to prevent the sexual offender from touching the breast of a female resident, R1. An Assistant Social Service Staff noticed R2 in immediate proximity to the cognitively impaired resident, R1, but failed to protect R1 by removing R2. The Social Service person went to find other staff; and when staff returned, R2 was caught fondling the breast of R1. Findings include: The July 2009 Physician's Orders indicate R1 is a female resident with diagnoses of Alzheimers Disease and History of Breast Cancer. The most recent assessment dated 7/22/09 indicates R1 is cognitively impaired, is incontinent of Bowel and	F9999		

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F9999	Continued From page 8 Bladder and needs extensive to total assist with all Activities of Daily Living. The Nurses Note dated 7/29/09 indicates something happened involving R1 on that date. The note states, "...Reviewed resident for adverse effects R/T (related to) incident this date. No marks, resident alert appears to be in no distress. Remains in Geri-Chair at this time with tray in place. Will monitor for adverse effects..." E1, the Administrator, stated on 8/15/09 at approximately 2:00 PM that the incident in the notes took place in July and that staff caught male resident (R2) touching the breast of female resident (R1). A progress note dated 7/29/09 reads, "...SSD (Social Service Department Staff) was walking through lobby (and) saw (R2, male) talking (with) (R1 female) (and) holding hands. (R1) always grabs for some ones hand to hold and I told him (R2) to go over and watch movie on big screen TV (a few feet away) (and) he said no he didn't like the movie. SSD went around corner to inform nurse...(and) CNA (E4) (Certified Nursing Assistant) was there so CNA went back around corner to re-direct resident (R2)..." E3, Social Service Assistant, on 10/15/09 at 2:00 PM, confirmed this note by stating, "...I was coming back from the dining room and I saw (R2) with (R1). I knew he was a sex offender so I went to get help at the nurses station. By the time the CNA got there (R2) was touching (R1's) breast. If I had it to do over again I would not have left him with her. I did not realize he could offend that fast. I have not had any training in dealing with sexual predators..."	F9999		

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F9999	Continued From page 9 The Facility Abuse Policy states, "...Annual training will also occur for all employees to recognize situations in which abuse is more likely to occur and how to intervene, such as: b. Characteristics of residents which have...known history of aggressive behavior..." Interview with E2, Director of Nurses on 10/20/09 at 12:30 PM confirmed E3 was not in the training that took place to warn staff of R2's sexual predilections. A written statement by the Certified Nursing Assistant (CNA) who discovered R2 fondling R1 is as follows: "...I was approached by (E3). She asked me if it was OK for (R2) to be in the main dinning [sic] room with a female resident who was grabbing his arm. I said no and went to go seppareted [sic] them and seen (R2) inappropriate touching her (R1's) chest..." R2 was admitted to the facility on 7/16/09 according to the "Pre-Admission Medical Financial Assessment." Comments on this document state, "...Patient is a registered sex offender..." A Social Progress Note dated 7/20/09 stated, "...Resident is a new admit with a strong history of fondling unalert/non-oriented females..." The admission packet contains a record titled "Illinois Sex Offender Information." This document shows R2 was convicted of "...Aggravated Criminal Sexual Abuse/Victim 13-16 (Years of Age) in Cook County, Illinois..." A Medicare Activity Progress Note dated 7/20/09 reads as follows, "...Resident is a 79 year old male who is alert and oriented x (times) three. Resident is capable of making his wants and needs known through clear speech. Resident enjoys independent leisure activities..." A note describing R2 dated 7/17/09 reads, "...Res (resident) is to [sic] high functioning and would	F9999		

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F9999	Continued From page 10 benefit in regular nursing care and activities..." A Memorandum dated 7/17/09 by the facility Social Service Department indicates the facility is aware of R2's recent conduct with cognitively impaired female residents and it reads: "...Social Services called this date to inform the resident's POA (Power of Attorney)...of a room change. During this phone call the POA provided a brief history of (R2's) sexual inappropriateness during stay at (previous facility and sister facility). In April of 2009, it was reported to POA that the resident had been observed to have 'wandering hands' , and that he had been fondling a non-alert and non-oriented female resident...POA declined to move his grandfather at that time...Within the next day or so the POA was contacted and informed of incidence[sic] (2) (the second occurrence) of inappropriate touching of a female resident. The POA was informed that he (R2) would have to move..." An undated Care Plan for R2 states, "...On 7/30/09, resident was inappropriately touching (breasts) (of a) non oriented, non verbal resident...On 7/31/09, resident was intercepted making movements towards another non oriented resident like he was going to touch other residents breasts..." E5, Licensed Practical Nurse, was asked about the other resident R2 had tried to touch on 7/31/09. E5 stated on 10/20/09 at approximately 11:10 AM. "...It was a number of residents in geri-chairs I don't remember their names..." E5, Licensed Practical Nurse (LPN) stated on 10/16/09 at 12:45 PM that R2 was able to side step the alarm system the facility had placed on his room. E5 stated, "...He was going in and out	F9999		

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F9999	Continued From page 11 through the bathroom and that was a problem with his supervision. A lot of the CNA's saw him going through the bathroom to side step the alarm..." E6, CNA stated on 10/16/09 at 3:30 PM that R2 was able to circumvent the alarm system the facility used to supervise him. E6 stated, "...He would get around his alarms. When he went in the new room he could get around the alarms. I said, there isn't anything wrong with this man cause he knows too much..." Observation of R2 on 10/16/09 at 10:00 AM shows a clean appearing elderly man, lean of body, small of frame, and straight posture. R2 was observed up ad lib and able to ambulate, albeit slowly. R2 was alert and oriented to person, place, and time. An interview with R2 on 10/16/09 at 10:00 AM in the facility he was transferred to after the incident indicates R2 was able to go where he pleased in the previous facility. R2 stated, "...I was able to walk around the building as I wanted to. I walked myself to my meals...The staff never watched where I was at, I went where I wanted to go...No, I never touched any of the ladies. Women are nothing to me. Women are nothing for me..." (A)	F9999		