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F9999	FINAL OBSERVATIONS Section 300.650 Personnel Policies d) The facility shall check the status of all applicants with the Nurse Aide Registry prior to hiring.	F9999		

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F9999	Continued From page 32 Section 300.3240 Abuse and Neglect 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. (Section 3-610 of the Act) 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. (Section 3-610 of the Act) 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. (Section 3-610 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 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) Based on interview and record review the facility failed to check the nurse aide registry prior to employment of staff (E14), immediately report to the administrator and investigate an allegation of abuse of a resident (R1) by staff (E14), and remove staff (E14) from contact with residents pending investigation of an allegation of abuse. The findings include: The Physician Order Sheet (POS) dated 1/1/05	F9999		

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for R1 documented diagnoses including Cerebral Vascular Accident, Anxiety and Dementia with Agitation. The Minimum Data Set (MDS) dated 12/26/04 documented R1 as being totally dependent on staff for all activities of daily living.

The nurses notes dated 1/6/05 for R1 documented, "difficult to arouse....refused breakfast and medications." The nurses notes dated 1/8/05 documented, "refused bedtime medications."

Review of the Medication Administration Record for R1 for January 2005 documented refusals of medication on 1/5/05 and 1/8/05.

During an interview conducted on 6/13/05 at 10: 45am, E5 (Certified Nursing Assistant - CNA) stated, "There was a lady (R1) here a while ago that has passed away. I saw E14 (LPN) nudge R 1 on the shoulder to take her medication. E14 stated, "You'll have a heart attack if you don't take the pill." E14's tone was not very nice."

During an interview conducted on 6/13/05 at 11: 00am, E6 (CNA) stated, "R1 passed away. E14 went to give R1 medication and she didn't want it. E14's voice was stern. E14 said, "If you don't want to take your pills it's fine with me!" and walked away. I don't remember if there was any physical contact."

During an interview conducted on 6/13/05 at 11: 10am, E4 (CNA) stated, "E14 on an every day basis forces residents to take pills. E14 hit a resident (R1) on one occasion. It was in the chapel. All of us (CNA's) witnessed and wrote it up. E23 (previous care plan nurse) is who we

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gave it to. E23 was to give it to the administrator and director of nursing (DON). We never got a response."

During an interview conducted on 6/13/05 at 3:45 pm, E21 (previous DON) stated, "I don't recall anyone giving me information regarding E14 hitting a resident. I remember someone telling me that E14 stated if the resident doesn't want to take them then he can't make them."

During an interview conducted 6/13/05 at 12:15 pm, E2 (Assistant Administrator) was asked if she had any abuse allegations/investigations since the last survey. E2 stated, "I'll have to look. I'm not sure I have any abuse investigations."

E2 submitted a paper stating, "List of Allegations of Abuse/Neglect since last survey 3/2005. There was one allegation listed on the sheet dated 1/13/05 involving R17 and reported to Illinois Department of Public Health (IDPH).

On 6/13/05 at 2:30pm, E2 and E3 (Acting Administrator/Corporate) were notified that a complaint had been filed that stated E14 had struck a resident on the shoulder because the resident was refusing medications and that administration never addresses abuse reports. E 2 stated, "I was not aware of this incident. I have heard of E14 being abrupt from the CNA's." E3 stated, "We will have to start an investigation."

The facility's Neglect and Abuse Policy and Procedure documented, "The resident has the right to be free from verbal, sexual, physical or mental abuse, corporal punishment and involuntary seclusion. Any complaint from an

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employee that he or she has heard or seen anything that may insinuate abuse to a resident will be thoroughly investigated by Administrator and Director of Nurses. All reports of actual or suspected abuse may be made without fear of retaliation. All employees of the facility shall report...situations of alleged abuse as they occur. The Department of Public Health shall be informed and a preliminary 24 - hour investigation report will be sent to the Department of Public Health. The Administrator or designee will file a Final Incident Report Investigation Report within 5 working days after the report of the incident."

The Resident Abuse Five Day Final Report Form regarding the allegation of abuse by E14 towards R1 was received on 6/17/05. The summary of findings by the facility documented, "Although there apparently was an event involving R1 the statements have many inconsistencies which make it impossible to prove the extent or intent. Several CNA's present believe E14 to be a good nurse and while he was impatient he did not intend any harm to the resident. CNA's did discuss in a CNA meeting that they felt E14's approach to residents was gruff.... It is the opinion of this administration that abuse did not occur."

During interviews conducted by the facility, during their abuse investigation, between 6/13/05 and 6/17/05 staff stated the following: E18 (CNA) - " The Director of Nursing (DON) asked if I saw the incident and I said yes. I wrote a statement and gave it to the DON."; E5 (CNA) stated, "E1 refused her medications. E14 reached out and nudged R1's shoulder.... I did not tell anyone. I think E4 (CNA) told someone."; E17 (CNA)

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stated, "I heard E14 raise his voice.... I think he was shaking R1, it was a little on the rough side. E14's voice sounded rough - aggressive. My opinion is he didn't like the resident. I did not report it to anyone. There was a letter written and I signed it. I suppose they gave it to the DON. Someone said the E23 (previous care plan nurse) had a copy."; E4 (CNA) stated, "E14 came in to give R1 her medications. R1 was kind of out of it and didn't respond. E14 got in R1's face, pushed R1's shoulder hard, R1's body shook in the geri-chair. E14 put the spoon in her mouth with the medication. Some went in R1's mouth and some went on her. E20 and I went and told E23. Then I wrote a letter and had the girls sign that they were witnesses. I gave it to E 23 who said she'd tell the DON and administrator ."

The nurse aide registry documented that E14 had a finding of abuse on 5/15/03. On 6/22/05 at 11: 30am, E2 was notified of the abuse finding for E 14 on the nurse aide registry. The allegation/ incident log for the nurse aide registry documented E14 had a finding of mental abuse on 5/15/03 for an incident that occurred on 2/20/ 03 at another facility.

During an interview conducted 6/15/05 at 2:45pm E14 was asked if he had ever been accused of abuse. E14 stated, "Yes, I have. They said I struck another resident at another nursing home."

During an interview conducted on 6/22/05 at 9:45 am, E2 stated, "We do a license background check but not a police background check. It would be redundant because if a person has any allegations it would go under their license. The

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F9999	Continued From page 37 CNA registry was not checked for E14." The facility's Monthly Staff Schedule for June 2005 documented E14 worked on 6/22/05, 6/23/05, 6/24/05, 6/27/05, 6/28/05, and 6/29/05. During an interview conducted on 6/29/05 at 8:30 am E24 (Director of Nursing - DON) was asked if E14 was still working in the facility? E24 stated, " Yes E14 is . We were informed by our legal department that E14 is exempt from the background check because of House Bill 3521." E24 was told that E14 could not work because of the abuse finding on the nurse aide registry. During an interview conducted on 6/29/05 at 9:00 am E3 was informed that E14 could not work due to the abuse findings on the nurse aide registry. E2 stated, "E14 is working due to information received from our legal department. E14's licensed and exempt from the healthcare worker background check." During an interview conducted on 6/29/05 at 3:30 pm E2 was asked why E14 was allowed to continue to work in the facility after being notified on 6/22/05 of a finding of abuse on the nurse aide registry? E2 stated, "I just do what I am told. It was the owner's decision to keep E14 employed." The facility's Neglect and Abuse Policy and Procedure documented, "Abuse prevention program contents: This facility will: 1) Conduct pre-employment screening of employees.; Pre-Employment Screening. Prior to a new employee starting a work schedule, this facility will; 3) Check the Illinois Nurse Aide Registry for all	F9999		

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F9999	Continued From page 38 CNA's. 4) File an Illinois State Police Healthcare Worker Background Check application for all CNA's, or verify with the Nurse Aide Registry that a background check has been completed within the past 12 months." The facility's policy does not state it will check the nurse aide registry for all employees. (A) Section 300.690 Serious Incidents and Accidents a) The facility shall notify the Department of any incident or accident which has, or is likely to have, a significant effect on the health, safety, or welfare of a resident or residents. Incidents and accidents requiring the services of a physician, hospital, police or fire department, coroner, or other service provider on an emergency basis shall be reported to the Department. 1) Notification shall be made by a phone call to the Regional Office within 24 hours of each serious incident or accident. If the facility is unable to contact the Regional Office, notification shall be made by a phone call to the Department's toll-free complaint registry number. 2) A narrative summary of each accident or incident occurrence shall be sent to the Department within seven days of the occurrence. b) A descriptive summary or each incident or accident shall be recorded in the progress notes or nurse's notes for each resident involved. c) The facility shall maintain a file of all written reports of serious incidents or accidents involving residents.	F9999		

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F9999	Continued From page 39 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 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. 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three	F9999		

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F9999	Continued From page 40 months. Based on observation, interview and record review the facility failed to determine the location of 1 of 13 residents (R2) assessed at risk for elopement prior to resetting an activated door alarm. R2 left the facility unattended for an unknown period of time without staff's knowledge on 4/2/05. The findings include: The Physician Order Sheet (POS) for R2 dated 4/1/05 documented diagnoses including Psychotic Disorder and Dementia of Alzheimer Type with Delusions & Behavioral Change. The Minimum Data Set (MDS) dated 3/15/05 for R2 documented short term memory problems, moderately impaired cognition, and the behavior of wandering. The nurses notes for R2 dated 4/2/05 at 9:45am documented, "Parking lot - side door alarm activated. Reset per staff. Then another resident noticed R2 walking outside - heading southwest (toward the grocery store). R2 was approached by staff members x 2 and escorted back inside of the facility. Family was informed and came over to visit and eat lunch with R2. E2 (Assistant Administrator) was also informed". During an interview conducted on 6/14/05 at 9:10 am Z1 (R2's family) stated, "They called me one evening to let me know R2 got out the side door the employees use. They told me R2 was heading towards the grocery store. R2 is like a 3 year old, you have to tell him to do everything."	F9999		

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During an interview conducted on 6/14/05 at 4:05 (regarding R2's elopement) E11 (Registered Nurse - RN) stated, "It happened after breakfast. I was passing medications when the nurse from the 100 hall came back with R2. She said R2 just went for a little walk. I heard parking lot door is open come over the loud speakers. I later found out that a housekeeper looked out the window on the door an didn't see anyone and went back on her break. A resident (R4) is the one that told the 100 wing nurse that R2 was outside. The side door isn't set up like the front door. I last saw R2 at 8:30am."

During an interview conducted on 6/14/05 at 2:38 pm E12 (Registered Nurse) stated, "I was on the floor doing my medication pass when someone said R2 left the building. I retrieved R2 and brought him back. R2 was in the grocery store parking lot, that's where I got him from."

During an interview conducted on 6/14/05 at 3:45 pm R4 stated, "R2 got out numerous times. R2 has been out in the parking lot before. I was looking out my window and saw R2. He was going to the grocery store. I think it was a Saturday. R2 made it to the grocery store parking lot. R2 was gone about 10 minutes. They thanked me for letting them know. It's the only reason they knew R2 was gone."

In an interview conducted on 6/14/05 at 9:50am E10 (Certified Nursing Assistant) stated, "The housekeeper turned off the alarm. R2 went out the employee door. They found R2 over by the grocery store."

During an interview conducted on 6/14/05 at 2:30

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F9999	Continued From page 42 pm E15 (Housekeeping Supervisor) stated, "E13 (Housekeeper) told me she reset the alarm but did not look out the door." In an interview conducted on 6/14/05 at 3:15pm E13 (Housekeeper) stated, "I got written up for it! E2 said I was getting written up because I didn't go outside and look. She said R2 ended up over in the parking lot of the grocery store. The nurse that was working that day told me she had to go get R2 at the grocery store. I didn't know it happened until I was told. On the weekend there is very little help. There is no one out at the nurses station." The Psychiatric Rehabilitation Service Level of Functioning assessment for R2 dated 12/04 documented R2 , "Needs substantial help to recognize and avoid common dangers and is frequently dependent upon others for decision making." In an interview conducted on 6/14/05 at 2:10pm E22 (previous Social Services) stated, "I remember seeing R2 in the hospital with E2. I did the form at that time. I have seen R2 try to go to the exit before." In an interview conducted on 6/14/05 at 2:42pm Z 3 (physician) stated. "R2 cannot leave the nursing home. R2 has very profound dementia. There is no way R2 could be outside the facility by himself. R2 would not be able to know what to do." The grocery store is located 1/10th of a mile from the facility. R2 had to cross 2 roads to get to the grocery store. The posted speed limit is 30	F9999		

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F9999	Continued From page 43 mile per hour. In an interview conducted on 6/14/05 at 11:45am E2 (Assistant Administrator) stated, "I did not know R2 got off the facility grounds. I didn't do an investigation because I didn't think this was an elopement. I did do an incident report that you are not aware of ". The incident log from the facility was reviewed and no incident was recorded for R2. E2 stated, "The DON is supposed to write it on the log." No incident report for the 4/2/05 incident with R2 was presented during the survey. A nursing Monthly Summary dated 3/28/05 for R2 documented, "Mental Status: Alert, Confused, Poor Memory and Wanders." The Wandering Assessment dated 12/16/04 for R 2 documented, "Does resident have history of wandering? Yes; Is resident at risk for wandering? Yes; Does resident need use of an electronic wandering device? Yes." The Resident Assessment Profile Dated 12/16/04 for R2 documented, "R2 is at risk for wandering... an electronic wandering device is in place at all times." The care plan for R2 dated 12/16/04 documented, "Potential for injury related to decreased standing balance and a new facility. Wandering." No approaches are listed on the care plan to address R2's wandering. Skilled Care Nurses Notes dated 12/13/04 4:00 am for R2 documented, "...tried to go out parking lot door...." The Skilled Nurses Notes dated 1/16	F9999		

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/05 at 4:00pm for R2 documented, "R2's speech is irrelevant not always pertinent to subject, often nonsensical. R2 paces about the facility, knows where his room is but doesn't know he is in a nursing home.; 7:45pm R2 has attempted to leave the building 4 times. R2 keeps saying he is going home".

On 3/15/05 at 10:55am R2 was observed and interviewed at another facility. During the interview R2 stated the month was "November". When R2 was asked what year it was he stated, "It's a secret". R2 was asked if he knew who the president was and stated, "Probably not". R2 was unable to state what town he currently was living in, where he was living or the address. When R2 was asked if he would know where he was going if he left here he stated, "That would be interesting". R2 stated he grew up and lived in Racine Wisconsin then lived in Chicago Illinois for a little while.

A psychiatric admitting note/consultation for R2 dated 12/3/04 documented, "R2 had been residing in Wisconsin until approximately one year ago."

The Activity Assessment for R2 dated 12/6/04 documented, "Town: "Poynette." Where do you currently live? " Alone." What problems are you having that makes it necessary for you to be here : " Had an automobile accident ." R2 thinks that's why he is here."

A list of residents with electronic monitoring devices (EMD) was found on 6/14/05 posted at the 100 nurses station clean utility room. The list was presented to E2 on 6/14/05 at 4:20pm. At

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145476	A. BUILDING _____ B. WING _____	C 07/06/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON HEALTHCARE CENTER	**811 SOUTH 10TH STREET OREGON, IL 61061**

(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
F9999	Continued From page 45 that time E2 updated the list by removing residents and adding other residents. The list identified R6, R7, R8, R9, R10, R11, R12, R13, R 14, R16, R17 and R18 as wandering residents. The 100 wing EMD weekly schedule check list identified R9, R10, R11, R12, R13, and R14 as having EMD's. The 200 EMD weekly schedule check list identified R6, R7 and R8 as having EMD's. R16, R17 and R18 were not on the lists for EMD weekly checks but were on the list for residents with EMD's that was updated on 6/14/ 05 by E2. (A)	F9999		