

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/13/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145395</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/24/2006</b>
NAME OF PROVIDER OR SUPPLIER  <b>REHAB &amp; CARE CTR - JACKSON CO</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1441 NORTH 14TH STREET MURPHYSBORO, IL 62966</b>		
(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	<p>Continued From page 20 Licensure Violations</p> <p>300.1210a) 300.3240a) 300.3240b) 300.3240d) 300.3240e)</p> <p>Section 300.1210 General Reuirements for Nursing and Personal Care</p> <p>a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) AN OWNER, LICENSEE, ADMINISTRATOR, EMPLOYEE OR AGENT OF A FACILITY SHALL NOT ABUSE OR NEGLECT A RESIDENT. (Section 2-107 of the Act)</p> <p>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)</p> <p>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)</p>	F9999			

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F9999	Continued From page 21  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 interviews and record review, the facility failed to prevent a staff member from deliberately agitating a cognitively impaired resident, by using a cell phone to videotape the resident (R6) while on the commode despite the resident's protests. The act appeared to agitate the resident as demonstrated on the video tape by the resident saying "stop that, get out," to the staff member doing the filming. The Certified Nurse Aide (CNA) that was filming the resident then shared the video with other employees on that shift. The facility staff that were aware of the video failed to immediately report the abuse to the supervisor on duty and/or administrative staff which allowed the CNA to complete her shift of work.  Findings Include:  1. Per review of R-6's Minimum Data Set (MDS) completed by staff on 08-31-06, R-6 requires total care for transfers, mobility and dressing. The MDS scores R-6 as a 2 for	F9999			

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F9999	<p>Continued From page 22</p> <p>cognitive ability which indicates that R-6 is moderately impaired.</p> <p>On 9-8-06, E-4's written statement indicates that on 09-07-06 E-7 (Certified Nurse Aid/ CNA) had a video recording of R-6 on the toilet with picture and sound. Per the statement, E-7 was making R-6 mad and filming it. E-4 went on to say that E-7 also had pictures of other residents stored on the camera. Per E-4, E-7 was showing the pictures to other staff and E-4 wrote that she "knew E-7 would show the pictures to people outside of the facility." Per interview with E-4 on 09-25-06 at 3:15 p.m. (with E-2 present), E-4 said that the incident occurred at approximately 7:30 to 8:00 p.m. while staff members were at the nurses desk to do paperwork. E-4 said that E-7 was laughing at the video and thought the incident was funny. Per E-4, she did not say anything to E-7 about the video at that time and did not report the incident to the RN supervisor because she was not sure if it was a reportable issue. E-4 said that later, as she drove home and thought about the actions of E-7, she made the decision to report it to the Administrator the next day. E-4 was asked about pictures of other residents on the cell phone and she said that they were friendly pictures, nothing that would be considered embarrassing for the residents.</p> <p>Per interview with E-5 (CNA), on 09-27-06 at 3:45 p.m., verification was given that he had been present when E-7 said to staff at the desk "you guys need to see this." Per E-5, he saw R-6 sitting on the commode and heard her yelling at E-7. Per E-5, R-6 could be heard on the video saying "stop that, get out of here." R-6 sounded angry. E-5 said that he knew it was wrong, but did not say anything to anyone.</p>	F9999			

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F9999	<p>Continued From page 23</p> <p>Per interview with E-6 (CNA) on 10-18-06 at 12:10 p.m., verification was received that she had viewed the video and thought it was "kind of abusive" and "embarrassing" for R-6. E-6 said that she saw R-6 sitting on the commode yelling, and R-6 seemed angry on the video. Per E-6, she did not report the incident to any supervisor.</p> <p>Per interview with E-19 (CNA) on 10-18-06 at 12:30 p.m., E-7 always had her cell phone with her. E-19 told E-7 that she should not have the cell phone with her as she worked. E-7 replied " don't worry I won't get caught."</p> <p>Per interview with Z-2 (local police officer) on 10-18-06 at 11:00 a.m., R-6's family wants to press charges against E-7 and told him that they would be in to sign the necessary papers.</p> <p>Per interview with E-2 (Director of Nursing) on 09-26-06 at approximately 3:00 p.m., verification was given that the incident had not been reported to supervisors on the night of 09-07-06, but was reported on 09-08-06.</p> <p>(A)</p>	F9999			