STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146038	A. BUILDING _____ B. WING _____	06/18/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE CITY REHAB & H C	825 E MAIN STREET, RR #2, BOX 97 PRAIRIE CITY, IL 61470

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F 496	Continued From page 47 believes will include information on the individual. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to check the nurse aide registry prior to employment for 1 of 10 recent hires (E10). Findings include: On 6/15/10 at 11:00 a.m., E10 (CNA - Certified Nursing Assistant's) personnel file indicates E10 (CNA) was hired by the facility on 7/09/09. E10 (CNA's) personnel file shows a check against the nurse aide registry was not performed until 8/17/09, a total of 38 days after E10 (CNA) was hired. On 6/15/10 at 12:05 p.m., regarding the untimeliness of the nurse aide registry check for E10 (CNA), E11 (Business Office Manager) stated, "I don't know. I just started a few months ago so I didn't personally do these someone else did. I kind of inherited a mess."	F 496		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS	F9999		

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F9999	Continued From page 48 300.610a) 300.1030a)2) 300.1210a) 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 300.1030 Medical Emergencies a) The advisory physician or medical advisory committee shall develop policies and procedures to be followed during the various medical emergencies that may occur from time to time in long-term care facilities. These medical emergencies include, but are not limited to, such things as: 2) Cardiac emergencies (for example, ischemic pain, cardiac failure, or cardiac arrest). 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 49 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. These REGULATIONS are Not Met as evidenced by: Based on interview and record review, the facility failed to honor 1 of 10 residents sampled (R17's) advanced directive. On 5-21-10, R17 was found unresponsive. Facility staff failed to initiate CPR (Cardiopulmonary Resuscitation) and R17 expired. Findings include: R17's Death and Discharge Record states R17 was admitted 5-14-10 with Metastatic Prostate Cancer. The death record shows time of death at 2:55 a.m. on 5-22-10. R17's nursing notes dated 5-22-10 at 1:55 a.m., state, "CNAs (Certified Nursing Assistants) went to room to check on resident and found him non-responsive. Unable to get apical heart rate. No breathing. Granddaughter outside building. Informed her and she called her mother." The next note at 2:10 a.m. states "Coroner...notified and given permission to call funeral home." Social Service notes dated 5-21-10 states "(R17) is doing as well as can be expected. He remains alert et (and) oriented...I spoke with him again concerning his code status and he remains firm that he wants full code..." R17 expired that night,	F9999		

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F9999	Continued From page 50 5-22-10 at 1:55 a.m. R17's POS (Physician's Order Sheet) for May 2010 states under code status "full code." R17's admitting face sheet states code status is full code. Facility's Social Service Interim Treatment Plan dated 5-14-10 shows R17 has no Advanced Directive on file and does not wish to make changes to the advanced directive. On 6-17-10 at 10:10 a.m., E18, RN (Registered Nurse) stated the following: On the night of 5-22-10, R17 was in bad shape at 10:00 p.m. 5-21-10 when she came on duty. R17's granddaughter was with R17 that night. Close to 1:55 a.m., R17's granddaughter went outside. Within 10 minutes she had the CNAs go to R17's room to turn him. A CNA came and got her as R17 was unresponsive. E18 checked R17 who had no heartbeat and no respirations and his skin was cool and damp. E18 went to get R17's granddaughter who was coming back into the facility. E18 told R17's granddaughter that R17 was unresponsive with no pulse and no respirations. E18 stated R17's granddaughter said to "leave him alone, he was at peace." E18 stated she did not know if R17 had been "gone" the whole 10 minutes or not. E18 stated "as bad as he was, there was no sense in starting CPR." E18 stated she was aware R17 was a full code. E18 stated it was her decision and no one else's to not initiate CPR. On 6-17-10 at 2:35 pm, E9 (CNA) stated she worked the night of 5-22-10 when R17 passed away. E9 stated around 2:00 pm that night, R17 family stepped outside after sitting with R17. E9 stated within minutes, E9 and another CNA entered R17's room and found him pale and	F9999		

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F9999	Continued From page 51	F9999		

unresponsive. They got the nurse who determined R17 had expired. E9 stated no one started CPR. E9 stated they had checked R17 less than one half hour before he was found. R17's family was with R17 at the last check.

On 6-17-10 at 11:10 a.m., E19 (Social Service Director) stated R17 came from the hospital with a full code status. E19 stated on 5-21-10 she again spoke with R17 regarding his code status. R17 stated he wanted to remain a full code. E19 stated R17 was adamant about remaining a full code even though he was on hospice with Metastatic Prostate Cancer. E19 stated R17 is alert and able to make his own decisions.

R17's POS (Physician Order Sheet) for May, 2010 shows R17 is receiving hospice services for diagnoses of Metastatic Prostate Cancer. Physician transfer sheet from the hospital signed 5-13-10 shows R17 was discharged to the facility on 5-14-10 on a full code status. R17's MDS (Minimum Data Set) dated 5-21-10 shows R17 to be independent with decision making and able to make himself understood.

On 6-17-10 at 10:15 a.m., E2 (DON/Director of Nursing) stated on 5-22-10, E18 RN called her regarding R17's death. E18 related family did not want CPR initiated. E2 stated "I know if you have a full code you have to do it."

On 6-17-10 at 9:45 a.m. and 10:00 a.m., E1 (Administrator and Registered Nurse) stated if someone who is a full code is found unresponsive with no pulse or respirations staff should initiate CPR. E1 stated if she had been working on 5-22-10 when R17 expired, she (E1) would have coded R17 per R17's instructions.

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F9999	Continued From page 52 On 6-18-10 at 8:30 a.m., E23 (Corporate Nurse) verified there was no DNR (Do Not Resuscitate) order with the contracting hospice facility. R17's Power of Attorney for Health Care signed 8-26-08 appoints R17's spouse as Health Care Power of Attorney. This documents states "the above grant of power is intended to be as broad as possible so that your agent will have authority to make any decision you could make to obtain or terminate any type of health care, including withdrawal of food and water and other life-sustaining measure, if your agent believes such action would be consistent with your intent and desires. If you wish to limit the scope of your agent's powers or prescribe special rules or limit the power or make an anatomical gift, authorize autopsy or dispose of remains, you may do so in the following paragraphs." On the same page, R17 has initialed the following statement "I want my life to be prolonged to the greatest extent possible without regard to my condition, the chances I have for recovery, or the cost of the procedures." The facility's Do Not Resuscitate Policy states "It is the policy of (this facility) that cardiopulmonary resuscitation and other emergency procedures will be initiated in all circumstances of a resident cardiac or pulmonary arrest unless a valid Do Not Resuscitate (DNR) order is written in the resident's record. The Cardiopulmonary Resuscitation policy revised 10/06 states "Cardiopulmonary resuscitation shall be initiated on all residents except those who have designated through advanced directives and/or have a specific	F9999		

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F9999	Continued From page 53 physician order for "DNR," "No Code," or "No CPR." All employees of this facility shall be certified in CPR within a reasonable time after hire and annually thereafter....If respirations are non existent or cease, place resident on hard surface (floor or back board) and initiate artificial respirations...If pulse is absent, initiate artificial circulation/chest compressions." (A) 300.615e) 300.615f) Section 300.615 Determination of Need Screening and Request for Criminal History Record Information e) In addition to the screening required by Section 2-201.5(a) of the Act and this Section, a facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act [20 ILCS 2635] for all persons 18 or older seeking admission to the facility. Background checks shall be based on the resident's name, date of birth, and other identifiers as required by the Department of State Police. (Section 2-201.5(b) of the Act) f) The facility shall check for the individual's name on the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections sex registrant search page at www.idoc.state.il.us to determine if the individual is listed as a registered sex offender. These REGULATIONS are not met as evidenced	F9999		

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F9999	Continued From page 54	F9999		

by:

Based on interview and record review, the facility failed to check the Illinois Sex Offender Registration website and/or the Illinois Department of Corrections website and / or initiate the criminal history background checks within 24 hours for 9 of the last 10 residents admitted, R17, R18, R20, R13, R16, R21, R22, R23, and R24.

Findings include:

1. Admission record shows R17 was admitted 5-14-10. R17's Criminal Background Check was not initiated until 5-24-10. R17's ISP website (Illinois Sex Offender website) and IDOC website (Illinois Department of Corrections website) were not checked until 5-21-10.

2. Admission record shows R18 was admitted 5-14-10. R18's Criminal Background Check was not initiated until 5-24-10. R18's ISP website and IDOC website were not checked until 5-21-10.

3. Admission record shows R20 was admitted 3-2-10. R20's IDOC website is dated as checked 6-15-10.

4. Admission record shows R13 was admitted 3-26-10. R13's Criminal Background Check was not initiated until 3-31-10. R13's ISP and IDOC websites were not checked until 3-30-10.

5. Admission record shows R16 was admitted 3-4-10. R16's Criminal Background Check was not initiated until 3-8-10.

6. Admission record shows R21 was admitted

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F9999	Continued From page 55 3-12-10. R21's Criminal Background Check was not initiated until 3-18-10. R21's ISP and IDOC websites were not checked until 3-17-10. 7. Admission record shows R22 was admitted 2-23-10. R22's Criminal Background Check was not checked until 3-3-10. 8. Admission record shows R23 was admitted 2-16-10. R23's Criminal Background Check was not initiated until 3-3-10. R23's ISP website was not checked until 3-2-10 and the IDOC website was not checked until 6-15-10. 9. Admission record shows R24 was admitted 12-26-10. R24's Criminal Background Check was not initiated until 12-30-09. The ISP and IDOC websites for R24 were not checked until 12-29-10. On 6-15-10 at 2:05 p.m., E11 (Business Office Manager) states she has recently been put in charge of completing the screens for new admissions. E11 states she tries to do the checks on day of admission. E11 states she thought she had ten days to initiate all checks. On 6-15-10 at 2:05 p.m., E24 (Corporate Staff) states shes not sure if they have a written policy but thought all the checks had to be initiated within ten days. (B) 300.3240a) Section 300.3240 Abuse and Neglect	F9999		

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F9999	Continued From page 56 a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. This REGULATION is not met as evidenced by: Based on observation, record review, and interviews, the facility failed to prevent verbal abuse to 1 of 10 residents sampled (R2) who was witnessed to be called names, cursed, intimidated, threatened and screamed at to swallow pills. Findings include: R2's current MDS (Minimum Data Set) dated 5/4/10, notes R2 to be 95 years of age with Diagnoses including: Dementia, Anxiety, and Congestive Heart Failure. It documents R2 to be severely impaired in cognition and to require extensive to total dependence for all activities of daily living. The report titled Incident Report/(state agency) Notification dated 5/10/10 at 10:00 pm documents that there had been alleged verbal abuse by a nurse (E14) toward (R2). The investigation of the incident includes written statements by the three midnight staff members on duty the night of 5/10/10. Interviews by some the staff follow each statement. The statements include the following: E15 (CNA/Certified Nurse Aide) wrote in her statement on 5/11/10, "When we came in 5/10/10 for 3rd shift, (R2) was sitting across from the nurse station. E14 (RN/Registered Nurse) was hollering at (R2) to leave her lap (cushion) on the wheelchair. (R2) was asking to go to the	F9999		

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bathroom. (E14) said that (R2) was a crazy b----, very loudly. (R2) was saying that she was bad but didn't know what she did wrong. (E14) said that (R2) was F---ing nuts and that she (E14) would like to kill her and then laughed. (E17/CNA) and I went ahead and clocked in so that we could take (R2) to the bathroom. Then (E14) gave (R2) her med cup and screamed in (R2's) face to swallow it, two times that I can recall. (E14) said not to put (R2) to bed until (R2) passed out in her wheelchair. (E17/CNA) went ahead and put (R2) to bed. (R2) slept all night. (E14) stated that she (E14) had given (R2) one of every thing that was loose in the med cart."

E17 (CNA) documented on her statement, no date, "I (E17) came to work 3rd shift on 5/10/10 and (R2) was sitting at the nurses' station. (E14/RN) was in the medication room. (R2) was saying that (R2) needed help. (E14) came out and said that she could not stand (R2) and that (R2) was a f---ing b----. (E14) said that she could kill her. (E14) then gave (R2) some pills. (E14) was yelling at (R2) to swallow the pills. Then (R2) said she had to go to the bathroom so I clocked in early and took her (R2). Then (R2) wanted to go to bed. (E14) told me not to put her to bed until she fell asleep in the wheelchair. I put her to bed any way and she slept all night long."

E17 (CNA) stated on 6/16/10 at 11:40 am, "I clocked in early that night because (R2) was by the nurse station asking for help over and over. The evening girls were down the hall doing bed checks. (E14/RN) said she'd kill (R2) if she could. (E14) came out of the med room and said that she couldn't stand that f---ing b----. (E14) brought out some pills for (R2) and yelled at (R2) to swallow this, swallow this. After that, (R2) said

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F9999	Continued From page 58 'I don't know why they treat me like this'. (R2) has said that before but maybe she had a reason." On 5/12/10 E16 (LPN/Licensed Practical Nurse) documented in her statement, "I came up to the desk last night after clocking in. (E14/RN) said that (R2) should be asleep in a few minutes as I gave (R2) every loose pill I could find in the med cart. (E14) said she is f----ing nuts and I asked (E14) who was nuts. (E14) said (R2). (E17) brought (R2) out of the bathroom and (E14) hollered not to put (R2) to bed until she falls asleep in that chair. (E17) put (R2) to bed anyway because she was begging. (R2) slept all night." E16 stated on 6/16/10 at 11:50 am, " I clocked in that night and (E14) stated, "(R2) will be knocked out soon. I gave (R2) every loose med in the med cart. (E14) said that she was f---ing crazy and I asked who was? (E14) stated that (R2) is. One of the aides brought (R2) out of the shower room and (E14) told her not to put (R2) to bed until she passes out. They went ahead and (R2) slept all night. The 2 to 3 nights prior (R2) was up most of the night." E1 (Administrator) stated on 6/15/10, "I suspended the three girls (E15-17) for not reporting the allegation until the next day." E1 was asked what about E14 whom they had alleged had done the abuse. E1 stated, "I called her and told her not to come back until we were done. She missed one day. I couldn't confirm the allegation because when I re-interviewed one of the girls changed her story about where (R2) was sitting when she came in that night and the evening shift didn't know anything about that stuff	F9999		

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going on. (E14) is an older nurse and she has been going through some hard times. I worked with her at another facility before we came here."

The investigation file did not contain any statement by E14, the alleged abuser. E14's employee file did not contain any counseling and did not contain a suspension form as did the files of E15-17.

On 6/17/10 at 2:10 pm, E9 (CNA) stated regarding the evening of 5/10/10, "I was working with (E14/RN) and I was training a new CNA (E22). That was our entire evening staff. We worked 2:00 pm to 10:pm and we got out on time that night. I did not see or hear anything going on because we were doing bed checks and as I said I wanted to get off on time. We were in and out of resident rooms not near the station. They got there just before 10 and we left at 10. We weren't in the building after 10 so we didn't know anything happened. I was so sorry to hear about those girls getting suspended because they won't put up with any abuse. I have seen (E14/RN) lose her patience at times. It's more her personality and she hasn't felt well after her surgery and her family loss. (E14) gets loud with the residents. More her personality. I've never known (E15 or 17) to be trouble makers and the nurse on nights, (E16) is very by the book, trustworthy, a very good nurse."

The only other staff member to work the evening of 5/10/10 (E22/(CNA) stated on 6/17/10 at 3:00 pm, "I didn't see anything, but I left shortly after the night girls got there. The other CNA and I had been in resident rooms doing bed checks and then we left so how would we know?"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146038	A. BUILDING _____ B. WING _____	06/18/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE CITY REHAB & H C	**825 E MAIN STREET, RR #2, BOX 97 PRAIRIE CITY, IL 61470**

(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 60 E14 (RN) stated on 6/17/10, "(R2) had a lot of horrible evenings before I got (R2) on Haldol. Yes, I gave her some Tylenol around 10:00 pm that night or whatever is on her MAR (Medication Administration Record) I'm not sure what I gave her." E14's MAR dated 5/10/10 was read to E14 as it contained a routine Tylenol Extra Strength at 8:00 pm not at 10:00 pm. E14 stated that some times it is difficult to get R2 to take her meds but she would document it if refused and given late. The MAR was again read and there was no documentation of any late routine medications, no PRN (as needed) medications and no scheduled medications at that time. E14 replied, "Well that's fine, whatever. I have never spoken like that to (R2). I did give report. I have no idea what I may have said in report. Those girls should have reported this to the Administrator immediately." R2 was observed sitting in a wheelchair with a soft lap cushion on the chair in her room on 6/17/10 at 1:30 pm. R2 was asked how the staff treat her. R2 stated, " What care? Who do you mean? My husband buys my food. I don't have any money you know. I'm very confused." The policy titled Abuse Prevention Program dated 8/29/10 states: "Verbal Abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or families, or within their hearing distance regardless of their age, ability to comprehend, or disability. Examples include, but are not limited to threats of harm and saying things to frighten a resident. Decision to proceed: Even if the resident might not comprehend disparaging comments, verbal or mental abuse might have taken place if the intent	F9999		