STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145978	A. BUILDING _____ B. WING _____	C 10/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAWNEE ROSE CARE CENTER	**1000 WEST SLOAN STREET HARRISBURG, IL 62946**

(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
F 000	INITIAL COMMENTS Complaint 1454613/IL72610	F 000		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to develop interventions and provide supervision to prevent a resident from wandering into other resident rooms for 1 of 5 residents (R2) reviewed for behavioral symptoms in a sample of 5. The findings include: According to the Minimum Data Sets (MDS) dated October 6, 2014, R2 is 75 years old, has a Brief Interview for Mental Status (BIMS) score of 3 indicating R2's cognitive skills for daily decision making is severely impaired, wandering behavior occurred daily, and requires supervision and setup help with ambulation. On October 21, 2014 at 2:00 PM, this surveyor attempted to interview R2 without success due to R2's inability to communicate about anything but "turnips" at that time.	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 323	Continued From page 1 The discharge summary from an inpatient behavioral treatment unit treating R2 on August 13, 2014 lists a diagnosis of "Dementia of the Alzheimer's type with late onset, with delirium". Nursing notes for R2 contain the following: "August 15, 2014 12:10 AM, Resident up and wandering around facility, getting into other's things. Redirected with some improvement", "August 26, 2014 at 2:00 AM, resident up ambulating to other resident rooms when redirected, resident hit CNA with fist, 1:1 given with little improvement, attempted to redirect with food and fluids resident refused", " September 2, 2014 1:30 AM Resident found in another resident's room, trying to hit R5 with R2's fist while R5 was in bed. Taken to bathroom, redirected to R2's room and assisted to bed", "September 9, 2014, Resident up and wandering around going into other's rooms." On October 21, 2014 at 12:50 PM, R1 reported R2 had entered R1's room and took a cane and sunglasses. R1 has a Brief Interview for Mental Status exam score of 15 indicating R1 is cognitively intact. On October 23, 2014 at 9:30 AM, R5 reported R2 came into R5's room twice, could not remember the specific dates but one time was in the early morning hours, R5 woke up to R2 "taking a leak on my arm" and R2 was "hitting my legs with his fists, it seemed like it took a while for the staff to come and I hollered for help the nurse came in and said R2 didn't belong in my room and took R2 out. R2 did not hurt me but I didn't like it. R2 came into my room again I am not sure if it was the same day or not to mess with the curtains, I hollered again and they came and took R2 out."	F 323		

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F 323	Continued From page 2 On October 22, 2014 at 3:55 PM, R6 reports R2 was told, R6 would "call the police if R2 did not leave, and my room mate gives R2 a dirty look and then R2 leaves. Once R2 came in and pee' d in the trash can and I don't like that. I think R2 is sick and don't think R2 knows where R2 is at or what R2 is doing." On October 22, 2014 at 11:50 AM, E2 (Director of Nursing, [DON]) verified receiving a report that "R2 went into R5's room and placed R2's hands on R5's bed side rails. R5 was yelling at R2 to get out of the room. R5 said R2 hit R5's legs but E5 (Licensed Practical Nurse [LPN]) was there and said R2 was standing beside R5's bed. R5 was yelling at R2 and that is what initiated the incident. R2 had just entered R5's room." On October 22, 2014 at 2:00 PM, E3 (Certified Nurses Aide [CNA]) stated "R2 enters other resident rooms daily and the staff intervene by saying go this way or that way, we try to redirect R2 and provide drinks or snacks. R2 doesn't like it when someone yells, R2 has not been aggressive lately. The CNA's document behaviors in a behavior book and list the interventions we try and if they were effective or not". When asked about training on what to do when a resident wanders into other resident rooms E3 states "The nurses let us know how to handle residents when they enter other resident rooms and the behavior book has different types of interventions listed to try." On October 22, 2014 at 2:20 PM, E4 (Minimum Data Set \ Care Plan Coordinator), reports believing "R2 is looking for something to do when R2 is entering other resident rooms. I use	F 323		

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F 323	Continued From page 3	F 323		

redirection and talk with R2 about maintenance issues, we get a bucket and let R2 sort things. R2 enter's other resident rooms a lot less than when R2 was first admitted, it is only 2 to 3 times a day now. If we see R2 on 200 hall we call out R2's name and that prevents R2 from going on into other resident rooms, there is a resident on hall 200 that does not get along with R2. None of the residents like R2 going into their rooms but no one gets aggravated specifically at R2. The staff at the facility have discussed R2 in the morning meeting before." When asked about training received to handle residents entering other resident rooms E4 stated "working the floor I have dealt with it a lot. If you determine the cause usually with R2 its the bathroom or looking for a place to lay down."

On October 22, 2014 at 4:30 PM, E5 (Licensed Practical Nurse [LPN] stated "R2 is given snacks and allowed to stay with the staff on night shift to keep R2 out of other resident rooms, or some sort of diversion. R2 is much more calm now, and rarely enters other resident rooms". When asked about training "most of my CEU (Certified Education Units) training regarding how to handle resident behaviors of entering other resident rooms are from dealing with Alzheimers. On September 2, 2014 when R2 was in R5's room, R5 turned on a call light on my way down the hall, I heard R5 yelling out and I ran down the hall. R2 was standing beside R5's bed trying to get to R5 but couldn't due to the bed's side rails. R5 stated "get R2 out of here R2 is trying to hit me, I did not notice urine on the bed or floor of R5."

R2 was observed wandering into E1's (Administrator) office on: October 21, 2014 at 2:00 PM, 2:45 PM, and 3:00 PM and was

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F 323	Continued From page 4 redirected to the bathroom and front lobby, R2 again wandered into E1's office on October 22, 2014 at 11:00 AM and redirected to the dining room. On October 22, 2014 at 1:30 PM, R2 was observed wandering unsupervised, down 200 hall after being taken down 200 hallway to go to the bathroom by E3, and at 3:40 PM, R2 was observed in room 102, unsupervised moving chairs from under the table located in the room. R2's care plan provided by E4 on October 21, 2014, does not specifically address R2 entering other resident rooms or other interventions to prevent the occurrences. Although staff interviews indicate R2 wanders in and out of resident rooms 2 to 3 times per day, the Behavior Monitoring records for October 2014 only document wandering behaviors for R2 on October 18, October 20 and October 21, 2014. E2 reported on October 21, 2014 at 10:15 AM, "I can't show you the incident accident logs or reports we use those as Quality Assurance tools, but I can show you the blank forms and tell you the process we go through".	F 323		