

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

PRINTED: 04/14/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146036	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/23/2005
NAME OF PROVIDER OR SUPPLIER SHAWNEE CHRISTIAN NURSING CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 1901 13TH STREET HERRIN, IL 62948		
(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 225	Continued From page 8 The surveyor confirmed that the facility took the following actions to remove the Immediate Jeopardy: 1. At approximately 6:30 pm on 03-16-05, E-6, CNA, told E-2, DON, what she observed on the evening of 03-13-05. E-2 immediately spoke with E-7, suspended E-7 indefinitely, and escorted E-7 out of the building. 2. The facility followed their policy and procedures on abuse and immediately started their investigation. 3. R-1 was sent to the emergency room per Z-2 's orders for an examination. 4. E-6, CNA, was suspended for 3 days without pay for failure to report to her supervisor as mandated in the facility abuse policy and will go through mandatory inservicing of the abuse policy and procedures. 5. The facility revised their abuse policy on 03-18-05 to address barriers to reporting abuse and the consequences to residents of "thinking" about reporting for a few days. 6. All staff were inserviced on abuse using the revised policies starting 03-18-05.	F 225			
F9999	FINAL OBSERVATIONS STATE LICENSURE VIOLATIONS: Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee	F9999			

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F9999	<p>Continued From page 9</p> <p>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>These REGULATIONS are not met as evidenced by:</p> <p>Based on record review, staff interviews, and resident interviews, it was determined that the facility neglected to assure that residents had an environment that was safe and free from inappropriate sexual abuse for 1 of 1 resident (R-1) who was involved in an allegation of staff-to-resident sexual abuse from the sample of 3. A facility staff member had knowledge of inappropriate sexual behavior by E-7, Certified Nurses Aide, directed toward R-1 and did not tell facility staff for 3 days. During that time, E-7 completed his shift on 03-13-05, worked a full shift on 03-14-05, and worked 4.75 hours on 03-16-05.</p> <p>The findings include:</p> <p>R-1 has been a resident in this facility since 07-21-04 and has diagnoses that included Alzheimer's Disease, Disturbance of Mood and behavior, and Depression. The most recent minimum data set dated 02-24-05 documents that R-1 has short and long term memory problems and is severely impaired for making daily decisions. This information was verified by interviews with E-2, Director of Nurses, and E-3, Assistant Director of Nurses.</p>	F9999			

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F9999	<p>Continued From page 10</p> <p>The facility incident report dated 03-17-05 documents that on 03-16-05 at 6:30 pm, E-6, Certified Nursing Aide (CNA), spoke with E-2, Director of Nurses, in his office. E-6 stated that on Sunday, March 13th, she entered E-1's room and saw E-7 in front of R-1 with his pants down far enough that his buttocks were exposed. R-1's legs were apart and at the height of his waist. E-6 did not see any penetration and stated that she did not enter the room except to open the door and place her head through the doorway. E-6 then closed the door and left the area.</p> <p>E-2 immediately paged E-7 and informed him of the serious allegation involving him sexually assaulting R-1 on the night of 03-13-05. E-7 was asked to write a statement about his activity with R-1 on that night, which he did. His statement stated that R-1 put her hands in his side pockets causing his pants to fall. E-7 was escorted out of the community exit by E-2 and told he was suspended indefinitely pending the findings of the investigation.</p> <p>E-2 contacted E-1, Administrator, Z-2, R-1's physician, Z-3, R-1's responsible party, and the Herrin Police Department.</p> <p>E-6 was interviewed by E-2 and E-3 regarding the 03-13-05 incident and why she did not report it until 3 days later on 03-16-05. E-6 stated to facility staff that she was afraid at first but knew she should report the incident.</p> <p>On 03-21-05 at 2:40 pm, E-6 was contacted by telephone for an interview. At that time she verified her statement and stated that she had been trained in the abuse policies and knew to</p>	F9999			

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F9999	Continued From page 11 report. E-6 stated she was "just stupid and scared" and the the more she thought, the more it bothered her. E-1, E-2, and Z-1 stated during interviews on 03-22-05 at 10 am that E-7 did not admit to sexual intercourse with R-1. E-7 did admit to inserting and removing his fingers in and out of R-1's vagina 10 to 12 times.	F9999			