STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145395	A. BUILDING ______ B. WING ______	C **03/22/2006**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHAB & CARE CTR - JACKSON CO	**1441 NORTH 14TH STREET** **MURPHYSBORO, IL 62966**

(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	FINAL OBSERVATIONS Licensure Violations Licensure Violations 300.1210a) 300.3240a)b)c)d) 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 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. Section 300.3240 Abuse and Neglect a) AN OWNER, LICENSEE, ADMINISTRATOR, EMPLOYEE OR AGENT OF A FACILITY SHALL NOT ABUSE OR NEGLECT A RESIDENT. (Section 2-107 of the Act) 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	F9999		

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F9999	Continued From page 9	F9999		

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)

Based on interviews and record review the facility failed to promptly complete a thorough and complete investigation into allegations of abuse for 1 of 4 residents from the sample. The resident was R-2. The facility also failed to implement any actions to protect other vulnerable residents from potental abuse during this time. The allegations were reported to the facility on 03-10-06 by a hospital case manager. The facility was told that the resident reported to a family friend that someone at the facility had thrown a shoe at him and dragged him on the floor. The case manager also reported to the facility that the resident had a bruise on his chest. E-3 contacted the case manager on 03-10-06 but failed to do any follow up with the investigation until 03-15-06 .

Findings Include:

1. During the initial tour of the facility on 03-15-06 at approximately 8:40AM., E-3 (Assistant Director of Nursing) reported to the surveyor that R-2 had been in the hospital recently and during the hospital stay R-2 had made verbal allegations of abuse by facility staff. Z-3 called the facility on 03-10-06 and reported the allegations of abuse that included a staff member throwing a shoe at R-2 and dragging him on the floor. Z-3 reported that R-2 did have a bruise on his chest.

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F9999	Continued From page 10	F9999		

Per E-3, no investigation had been done into the allegations made by R-2. E-3 said that on 03-14-06 she had 3 new admissions to complete and on 03-15-06 the Public Health Surveyor was present . She had not had time to do the investigation.

Per review of a nursing assessment that was dated 03-13-06, R-2 was readmitted to the facility with a 13cm. by 6cm. purple/yellow bruise on the lower left chest and a 3cm. by 3cm. purple bruise on the mid chest area. The assessment also stated that R-2 had a 6cm. by 6cm. bruised area to his coccyx. The chest area bruise was observed on 03-16-06 at approximately 10:30AM. , with E-3. The area appeared as charted on this date. Interview with R-2 was attempted but confusion to time and place was evident. R-2 could not tell surveyor what had happened to cause the bruise. The bruise described on the coccyx was not observed due to resident being ready to leave for dialysis. No staff member interviewed had been aware of the chest area bruises before R-2 had been admitted to the hospital on 03-10-06.

The facility completed their investigation on 03-16 -06 and had no findings of abuse. To date there is no determiniation of how the bruising on R-2's chest occurred.

(A)