STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145772	A. BUILDING _____ B. WING _____	01/17/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ODD FELLOW-REBEKAH HOME	**201 LAFAYETTE AVENUE EAST MATTOON, IL 61938**

(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 56 LICENSURE VIOLATIONS Section 300.1210a) Section 300.3240a)b)e) 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 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. Restorative measures shall include at a minimum the following procedures: 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) 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) These Requirements are not met as evidenced	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145772	A. BUILDING _____ B. WING _____	01/17/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ODD FELLOW-REBEKAH HOME	201 LAFAYETTE AVENUE EAST MATTOON, IL 61938

(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 57 by: Based on observation, interview and record review the facility failed to protect residents from involuntary seclusion, physical and mental abuse by not immediately reporting and investigating 3 of 3 allegations of abuse(R22, R27, R28). The failure of the facility to immediately report witnessed involuntary seclusion of R22 by a Registered Nurse(R.N.) resulted in further physical and mental abuse of two residents(R27, R28). The same R.N. physically held R27 down, forcing R27 to take medications, and threatened R28 with an injection of Ativan if R28 did not take medications. Findings include: 1. R22's current Physician Order Sheet(POS) states that R22 has a diagnosis of Dementia. The Minimum Data Set(MDS) dated 11/20/06 states that R22 has long/short term memory problems, is cognitively impaired, has behaviors of anger, wandering, resisting care and socially inappropriate behavior. The MDS states that R22 is independent with transfers and ambulation, and is continent of bowel and bladder. The facility report titled "Report to Public Health Department of Resident Incident," dated 12/27/06, states that on 12/20/06 at 10:10pm a nurse (E18,R.N.) "locked" R22 in his room. E20, Certified Nurse Aide (CNA) stated in interview on 1/8/07 at 10:20 a.m. that on 12/20/06 around 10:00 p.m. R22 was agitated and banging on the exit door. E20 stated she asked E31, CNA, to stay with R22 and went and got E18, R.N. E20 stated that E18 and E31	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145772	A. BUILDING _____ B. WING _____	01/17/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ODD FELLOW-REBEKAH HOME	**201 LAFAYETTE AVENUE EAST MATTOON, IL 61938**

(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 58 escorted R22 to his room and told him to go to bed. E20 stated that R22 got more agitated and E18 shut the door and told him to go to bed. E10 stated, "[R22] tried to open the door several times, [E18] closed it, then finally [E18] held it[door] shut about a minute or a couple of minutes." E20 stated she went over to the nurses station, because "I did not agree with what was going on." E20 stated that E18 talked to R22 in a very stern voice. E20 stated, "I didn't know what to do-she's(E18) my boss. I removed myself from the situation. [E18] stood there awhile and [R22] would open [the door], see [E18] and slam it shut." E20 stated that she told E21, Licensed Practical Nurse(LPN) and other co-workers what happened with E18 and R22. E20 stated that she could not remember if she reported the incident to E21 the night it happened(12/20) or if she waited until the next time she worked with her. E20 confirmed that E18 worked until 6:00am the next morning. E20's written statement dated 12/27/06 confirms information given by E20 in the interview. E21, LPN, stated in interview on 1/8/07 at 10:55 a.m. that she did remember E20 reporting the incident with R22 to her, but "did nothing with it that night, as she was busy." E21 stated when she went over to the unit later that night, R22 was in bed. E21 stated she did mention the incident with R22 and E18 to E22, LPN when she talked with her. E8, LPN, stated in interview on 1/8/07 at 11:20 a.m. that she relieved E18 on 12/21/06 at 6:00 a.m. E8 stated that on 12/21/06 E18 told her that she(E18) had "physically barricaded" R22 in his room. E8 stated that she did not believe E18. E8	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145772	A. BUILDING _____ B. WING _____	01/17/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ODD FELLOW-REBEKAH HOME	**201 LAFAYETTE AVENUE EAST MATTOON, IL 61938**

(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 59 stated when R22 "came out of his room, he looked so disheveled. [R22] came up to me and said, I'm so sorry, I won't do it again." E8 stated that night(12/21) she talked to E22, LPN, and E22 told her that she had reported the incident with R22 and E18 to E2, Director of Nurses(DON). E22, LPN, stated in interview on 1/8/07 at approximately 9:45 a.m. that on 12/21/06 at around 10:00 a.m. she received a phone call at home from E18, RN. E22 stated she was told by E18 that R22 was "loud and following [E18] around, not aggressive, and [E18] did not like it. [E18] took [R22] to his room, so he couldn't leave, said she[E18] stood in the doorway." E22 stated that she told E18 that when R22 acts like that he needs to go the bathroom and asked if she had done that. E22 stated that E18 said "no." E22 stated that she immediately on 12/21/06 called E2, DON, as soon as E18 hung up, and reported what E18 had confessed to her. E22, LPN's, written statement dated 12/27/06 accurately reflects the interview with E22 with the following additions: "She physically removed [R22] from the common area to his own private room, and instructed staff that [R22] was not permitted to leave his room until he calmed down. [E18] also bluntly-according to her own narrative-informed the resident that he was not allowed to leave, and then according to the report [E18] gave me, [E18] barred [R22's] exit from the area. [E18] told [E22] that she kept [R22] sequestered for approximately 45 minutes, in which during that time she did not attempt any other interventions to calm the resident, or attempt to discover the root of his agitation."	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145772	A. BUILDING _____ B. WING _____	01/17/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ODD FELLOW-REBEKAH HOME	**201 LAFAYETTE AVENUE EAST MATTOON, IL 61938**

(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 E2, DON, stated in interview on 1/8/07 at 2:10 p.m. that E22 did call him on 12/21/06, but only told him to check the charting in R22's nurses notes, not telling him about the allegation of E18 barricading R22 in his room. E2 stated R22's nurses notes did not say anything and he did not think anything about it. E2 confirmed that he became aware of the allegation involving R22 and E18 on 12/27/06 and that is when the investigation was begun. E2 stated, "It looks like I was told but didn't do anything about it." The facility "Time Card Report" dated 1/4/07 for hours worked from 12/17/06 to 12/30/06 states that R22 worked the following days: 12/20/06--5:55pm to 6:03 a.m. The allegation of involuntary seclusion involving E18 and R22 occurred on 12/20/06 around 10:00 p.m. 12/23/06--5:55pm to 6:10 a.m 12/24/06--8:01pm to 6:10 a.m. 12/25/06--5:48pm to 10:00 p.m. 12/25/06--10:01pm to 6:02 a.m. E22, LPN, was reinterviewed on 1/8/07 at 2:30 p.m. and stated that she told E2 that E18 had called her and confessed that she had forced R22 into his room because he was loud and following her around. E22 stated she also told E2 that she knew that was resident abuse. E22 stated that she thought E2 told her that he would look into it. E2 stated that on her written statement she had put in that she notified E2. When shown a copy of the written statement E22 stated, "The final sentence of my statement has	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145772	A. BUILDING _____ B. WING _____	01/17/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ODD FELLOW-REBEKAH HOME	201 LAFAYETTE AVENUE EAST MATTOON, IL 61938

(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 61	F9999		

been taken off the [copy] statement. At the end of the statement I typed that approximately 5 minutes after speaking to E18, I informed my DON(E2) of what E18 confessed to me."

E18, RN, stated in interview on 1/9/07 at 11:00 a.m. that R22 was trying to go out the doors, so she tried to get him to lay down. E18 stated, "I stood at the door when [R22] tried to come out." E18 denies holding R22's door so R22 could not get out.

E4, LPN stated in interview on 1/10/07 at 10:00 a.m. that she heard a rumor on 12/27/06 about R22 and E18. E4 stated she immediately called E1 and reported the allegation.

E1, Administrator, stated in interview on 1/8/07 at 2:05 p.m. that she became aware of the allegation involving R22 and E18, when told by E4, LPN, that she had heard that E18 had locked a resident(R22) in their room. E1 stated she investigated the allegation and felt comfortable terminating E18's employment with the facility.

E18's personal file was reviewed. The facility form titled Personal Action dated 12/27/06 states that E18 was suspended on 12/27/06 for an incident that occurred on 12/20/06. The facility form titled Separation Notice dated 12/27/06 states that E18 is being "discharged" for "unacceptable performance" and unacceptable conduct regarding incident of 12/20/06."

2. E8, LPN, stated in interview on 1/8/07 at 11:20 a.m. that a couple of days after the R22 incident(12/20), "[E18,RN] told me that she(E18) had straddled R27 to have her take her medicine(Risperdal). That same evening [E18]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145772	A. BUILDING _____ B. WING _____	01/17/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ODD FELLOW-REBEKAH HOME	**201 LAFAYETTE AVENUE EAST MATTOON, IL 61938**

(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 62	F9999		

told me she told R28 if you don't take this pill, I'm going to give you a shot of Ativan. [E18 told me this. I let it go in one ear and out the other. I'm not sure where she's coming from. This was after the incident with R22. Again I didn't believe her." E8 stated that she would consider what E18 told her, abuse if it really happened. E8 stated she did not immediately report to anyone what E18 confessed to her about R27 and R28. E8 stated she was troubled about the conversation with E18 and talked to E21, LPN, about it. E8 stated she was told by E21 to go to E1 the next day(12/27).

E20, CNA, stated in interview on 1/8/07 at 10:20 a.m. that she came back from emptying barrels and E18 told her, "Your little buddy[R27]-You need to talk to her. I sat on her because she was going in other residents rooms." E20 stated that E18 was talking about R27. E20 stated that she did not report what E18 alleged she had done to R27.

E18, RN, stated in interview on 1/9/06 at 11:00 a.m. "[R27] was swinging at me and other residents. I sat her in a chair and put my leg over her leg to keep her from kicking me." E18 denies straddling or forcing R27 to take her medications. E18 stated, "I did put my leg over the top of her leg while she was in the recliner to protect myself." When asked why she didn't just move away from R27, E18 stated, "I didn't move away because she was going to hit other residents." When asked when the incident with R27 occurred E18 stated, "sometime in December." When asked if she had ever threatened R28 with a shot if she didn't take her medicine, E18 stated, "Yes I did tell [R28]that she had to take her pills or we would have to give her the shot." E18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145772	A. BUILDING _____ B. WING _____	01/17/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ODD FELLOW-REBEKAH HOME	201 LAFAYETTE AVENUE EAST MATTOON, IL 61938

(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 63 stated that R28 then took her pills. E1, Administrator, stated in interview on 1/8/07 at 2:05 p.m. that she was not aware of staff reporting any allegations about R27 or R28. The current POS states that R27 has a diagnosis of Dementia. The MDS dated 12/6/06 states that R27 has long/short term memory problems, is cognitively impaired, has behaviors of wandering, requires supervision for transfers/ambulation and is continent of bowel and bladder. The care plan dated as reviewed on 11/16/06 has the following approaches identified for R27: Respond to R27 in a calm manner; Avoid commands using Don't or No. Use positive terms; reduce distractions and negative environmental stimuli (loud voices, multiple conversations); Is easily distracted. The current POS states that R28 has a diagnosis of Alzheimer's. The MDS dated 10/10/06 states that R28 has short term memory problems, is cognitively impaired, is independent with transfer/ambulation and is occasionally incontinent of urine. (A) Section 300.1210a) Section 300.1210b)6) Section 300.1220b)1-4,7-10) Section 300.3240a)f) Section 300.7020a)2)e) Section 300.7020b)2) Section 300.7060a) Section 300.1210 General Requirements for	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145772	A. BUILDING _____ B. WING _____	01/17/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ODD FELLOW-REBEKAH HOME	**201 LAFAYETTE AVENUE EAST MATTOON, IL 61938**

(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 64 Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest 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. Restorative measures shall include at a minimum the following procedures: b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. b) The DON shall supervise and oversee the nursing services of the facility, including: 1) Assigning and directing the activities of nursing service personnel. 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs.	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145772	A. BUILDING _____ B. WING _____	01/17/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ODD FELLOW-REBEKAH HOME	**201 LAFAYETTE AVENUE EAST MATTOON, IL 61938**

(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 65 Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. 4) Recommending to the administrator the number and levels of nursing personnel to be employed, participating in their recruitment and selection and recommending termination of employment when necessary. 7) Coordinating the care and services provided to residents in the nursing facility. 8) Supervising and overseeing in-service education, embracing orientation, skill training, and on-going education for all personnel and covering all aspects of resident care and programming. The educational program shall include training and practice in activities and restorative/rehabilitative nursing techniques through out-of-facility or in-facility training programs. This person may conduct these programs personally or see that they are carried out. 9) Participating in the development and implementation of resident care policies and bringing resident care problems, requiring changes in policy, to the attention of the facility's policy development group. (See Section 300.610(a).) 10) Participating in the screening of prospective residents and their placement in terms of services they need and nursing competencies available. Section 300.3240 Abuse and Neglect	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145772	A. BUILDING _____ B. WING _____	01/17/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ODD FELLOW-REBEKAH HOME	**201 LAFAYETTE AVENUE EAST MATTOON, IL 61938**

(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 66 a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act) 300.7020 Assessment and Care Planning a) Resident assessments, in addition to requirements in other applicable State and federal regulations, shall include a standardized, functional, and objective evaluation of the resident ' s abilities, strengths, interests, and preferences. The assessment shall be completed within 14 days after admission. 2) Assessments shall include at least the following: E) behavior triggers; effective calming approaches, and an analysis of each of the resident ' s patterns of dementia-related behaviors, such as wandering, agitation, anxiety, and safety issues; and 300.7020 Assessment and Care Planning b) The care plan shall be developed by an interdisciplinary team within 21 days after the	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145772	A. BUILDING _____ B. WING _____	01/17/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ODD FELLOW-REBEKAH HOME	**201 LAFAYETTE AVENUE EAST MATTOON, IL 61938**

(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 67 resident ' s admission to the unit or center. The interdisciplinary team shall include, at least, the attending physician, a nurse with responsibility for the resident, other appropriate staff in disciplines as determined by the resident ' s needs, the resident, the resident ' s representative, and the certified nursing assistant (CNA) who is primarily responsible for this resident ' s direct care, or an alternate, if needed, to provide input and gain insight into the care plan. Others may participate at the discretion of the resident. 2) As new behaviors manifest, the behaviors shall be evaluated and addressed in the care plan. Section 300.7060 Environment a) The environment (cultural, social, and physical) shall support the functioning of cognitively impaired residents. It shall accommodate behaviors, maximize functional abilities, promote safety, and encourage residents' independence by compensating for losses resulting from the disease process in accordance with each resident ' s care plan. These requirements are not met as evidenced by: Based on observation, interview and record review, the facility failed to provide adequate supervision for 1 of 1 sampled resident with physically aggressive behaviors(R24). Staff failed to provide ongoing assessment of repeated physical aggression and implementation of alternate interdisciplinary interventions beyond medication adjustments to ensure adequate	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145772	A. BUILDING _____ B. WING _____	01/17/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ODD FELLOW-REBEKAH HOME	201 LAFAYETTE AVENUE EAST MATTOON, IL 61938

(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 68	F9999		

supervision of R24. This lack of supervision resulted in repeated physical altercations between R24 and twelve residents.

Findings include:

1) According to the Admission Sheet, R24 had diagnoses which included Alzheimers disease with psychosis. According to the most recent Minimum Data Set (MDS) Assessment dated 11/2/06, R24 had indicators of delirium by having periods of restlessness and lethargy and being easily distracted. R24 was also assessed as having persistent anger with a decline in mood. R24 displayed the behaviors of wandering, resisting care, socially inappropriate behaviors, and physical abuse. On the Quarterly Review narrative dated 11/03/06 and signed by the physician, staff have documented "(R24) wanders daily.....(R24) is also physically abusive 1 to 3 days per week."

The Admission Sheet shows that R24 was admitted to the facility's Harmony Unit (Alzheimers Unit) from another facility on 8/3/06. In review of the admission packet, there is a History and Physical dated 7/2/06 on which the Physician, Z4, documented, "I got a phone call from (a facility) stating that (R24) had become extremely disruptive and had had a dramatic change in his mental status. (R24) had assaulted several of the personnel and they were totally unable to manage him." On another Consultation form, dated 3/27/06, in the Admission packet, Z7, Psychiatrist, documented that R24 had a history of sexual aggression, "(R24's) aggression has increased and also sexual behavior. (R24) is going around touching the female residents and the female staff. Occasionally he goes out and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145772	A. BUILDING _____ B. WING _____	01/17/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ODD FELLOW-REBEKAH HOME	**201 LAFAYETTE AVENUE EAST MATTOON, IL 61938**

(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 69 hits people in an unprovoked sort of way." On 1/09/06 at approximately 2:00 p.m., E6, Social Service Director (SSD), was shown the last page of the admission packet on which the Psychiatrist at another facility identified that R24 had sexual behaviors of inappropriate touching of other female residents. E6, stated that he had not previously seen it. E6 stated that if he had known this, he would have brought it to the attention of E1, Administrator, who probably would have "nixed" the admission, particularly, since R24 had exhibited these sexual behaviors toward other female residents. Further review of the record showed that consultations on 7/13/06 and 8/1/06 with Z5, a Psychiatrist, showed that Z6 had diagnosed R24 with "Bipolar I Disorder, Mixed." During a discussion with E1, the Administrator, at approximately 5:15 p.m. on 1/10/07, she stated that she was unable to get a diagnosis of Mental Illness (MI) for R24. E1 stated, "If I had had an MI diagnosis I could have transferred (R24) out of the facility." E1 stated without an MI diagnosis that she had to readmit R24 back to the facility after hospitalizations. Review of the nurses notes for R24 from admission showed multiple incidents of physical aggression by R24 beginning 8/23/06 and continuing until 1/2/07 when R24 was involuntarily discharged from the facility. The nurses notes entries are as listed below: 1) 8/23/06 - 8:30 p.m. "(R24) struck fellow resident (R36) with open hand about the face." According to the incident report R24 slapped R36	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145772	A. BUILDING _____ B. WING _____	01/17/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ODD FELLOW-REBEKAH HOME	**201 LAFAYETTE AVENUE EAST MATTOON, IL 61938**

(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 70 in the right eye. 2) 8/23/06 - 9:00 p.m. "(R24) found striking with both closed and open hand a fellow resident (R29) causing...some minor scratches." 3) 9/25/06 - 5:00 p.m. "(R24) hit two other residents in the face unprovoked within 10 minutes." 4) 10/07/06 - 3:30 p.m. "(R24) found in another resident room hitting (R25) in the face with a paper." 5) 10/12/06 - 4:00 a.m. "(R24) ambulating past (dining room) and hit another (patient) in (upper left) arm." 6) 10/13/06 - 3:00 p.m. "(R24)...smacked another (resident) in back and then grabbed other (resident) ear and wouldn't let go..." According to the Behavior Tracking Sheet, "(R24) walked up to another resident and started to slap (them) several times then (R24) put the other resident into a headlock and started slapping (them) several times." 7) 10/18/06 - "(R24) smacked a female resident repeatedly." 8) 10/30/06 - 1:00 a.m. " (R24)....found punching female resident (R25)." 9) 11/17/06 - 7:00 p.m. R24 "hitting and swinging at (R29), (R29) ..fell to the floor. (R24) did hit (R29)in the face." 10) 11/17/06 - 9:00 p.m. R24 "came into (R10) room and punched (R10) in the stomach 4 times and then in the neck." 11) 12/16/06 - 6:00 p.m. "(R24) smacked at another resident (R39) who was sitting in hall yelling 'help'. Got near resident face stating 'You son-of-a-bitch'.." 12) 12/17/06 - 1:00 p.m. "(R24) going in and out of other resident rooms, went into (R23's) room and was hitting (R23) for no apparent reason." 13) 12/18/06 - 6:15 p.m. "(R24) walking down	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145772	A. BUILDING _____ B. WING _____	01/17/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ODD FELLOW-REBEKAH HOME	201 LAFAYETTE AVENUE EAST MATTOON, IL 61938

(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 71 hall. Passed (R41) sitting in (wheelchair). Knocked glasses off of (R41)..." According to the Occurrence Report, R41 had bruising to the right eye brow. 14) 12/20/06 - 7:00 a.m. "(R24) entered (R32's) room, swung at (resident) causing (R32) to receive 2 skin tears." 15) 12/20/06 - 2:00 p.m. "(R24) entered another resident room hitting resident in (left) arm...." 16) 12/27/06 - 5:40 p.m. "(R24) was yelling at another resident and both were slapping at each other." 17) 01/02/07 - 6:54 p.m. "(R24) walked into room from another hall and used a water pitcher to strike resident many times over extremities." 18) 01/02/07 - 7:00 p.m. R7 "Heard roommate screaming 'Help' several times. Found (R7) in bed awake -says (R24) came in shut their door and proceeded to strike (R21) with a water pitcher multiple times. (R24) tried to choke (R7) ....must of grabbed (R7's) lower arm." On the Occurrence Report dated 1/2/07 at 7:30 p.m. in response to the "Nurse statement of other contributing factors:" staff have documented, "West Hall nurses evidently were not monitoring (R24) being a known combative type resident." During interview during tour at approximately 10:00 a.m. on 1/7/06, R21 stated, "a resident came in to my room, closed the door and began hitting me with my water pitcher. (R24) broke the pitcher hitting me." R21 had a bruised left thumb, bruised right thumb and palm. R21 stated that she was to have her thumbs x-rayed on 1/8/07. R21 stated that her family member came to the facility and sat in the doorway stating that they were not leaving until (R24) was out of the building. R21 stated that the Police were called. R21 said that she was still upset by this incident.	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145772	A. BUILDING _____ B. WING _____	01/17/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ODD FELLOW-REBEKAH HOME	**201 LAFAYETTE AVENUE EAST MATTOON, IL 61938**

(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 72 R21 stated, "I kept pushing the over-the-bed table into (R24) until I pushed him across the room and (R24) fell on my roommate. I can't walk anymore, so I crawled to the doorway and opened it and hollered for 'Help' until someone came." During interview with R7 at 10:10 a.m. on 1/11/2007, R7 stated that she remembers being struck and hit by (R24). R7 stated "he twisted my arm and bruised it. (R24) said (R24) would break my arm. (R24) tried to choke me. R7 said, "I'm scared to death of him." Observation of R7's arm showed that there were two finger-print size bruises on the left inner forearm. During interview with R23 on 1/10/07 at 10:45 a.m., R23 stated, "(R24) hit me and hit my girlfriend too (R21). (R24) tried to hit me in the eye but I dodged (R24). (R24) knocked my glasses off. (R24) hit me from my shoulders up. (R24) came in to (my) room, was standing in front of (the) closet." R23 stated she hollered for help. "I couldn't do nothing. (R24) scared me to death. You know, that still makes me nervous." R23 stated, "I had a bruise under (my) left eye, right here on the bone (R23 pointing to outer orbit of left eye)." "After that," (R23) stated, "I would go to the door and look out into the hall to make sure that (R24) was not around before going out into the hallway." Review of the Occurrence Reports showed that staff completed an Occurrence Report for only 8 of the 19 incidents involving altercations between R24 and other residents. When questioned on 1/11/07 at approximately 2:00 p.m., E2, the Director of Nursing, stated that he did not have incident reports for the additional altercations. E2	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145772	A. BUILDING _____ B. WING _____	01/17/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ODD FELLOW-REBEKAH HOME	201 LAFAYETTE AVENUE EAST MATTOON, IL 61938

(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 73 did identify a few of the residents involved, however, there were other incidents recorded in R24's nurses notes in which E2 stated that he did not know who the other residents involved were. When questioned about R24, on 1/10/07 at 10:00 a.m., E24, Licensed Practical Nurse (LPN) stated that R24 was very combative and had behaviors. E24 said that R24 was moved to the west wing of the facility, out of the Alzheimers Unit, on 12/06/06 because he was using a wheelchair for mobility and no longer qualified for the Alzheimers Unit. E24 stated that she witnessed R24 hit R40, however, because there was no visible injury, she did not fill out any reports or enter a note in the nurses notes. E24 stated that staff did not always fill out an injury report for every incident if there was no injury. E24, LPN, stated that R24 had hit R39, however E24 was unable to locate any information documenting the incident on the behavior monitoring sheets or in the nurses notes. E24, LPN, stated that other residents were afraid of R24 because R24 was all over the place. R24 wandered in and out of resident rooms. E24 stated that if there were injuries or a resident was very upset then staff would chart about it. E24, LPN, stated that staff were also afraid of R24 and would attempt activities knowing that R24 would go off without warning. Staff tried not to stimulate R24 too much. During interview with E32, Certified Nurse Aide (CNA), on 1/9/07 at 10:25 a.m., she stated that R24's behavior was sporadic.E32 also stated, "(R24) had sundowners, would wander and get agitated. (R24) would cuss and hit (other residents) at the nurses station (as) (R24) did not like other residents 'hollering out.' (R24) would	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145772	A. BUILDING _____ B. WING _____	01/17/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ODD FELLOW-REBEKAH HOME	201 LAFAYETTE AVENUE EAST MATTOON, IL 61938

(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 74	F9999		

cuss at them and tell them to shut up. The yelling and swearing happened mostly at the nurses station, so I think the other nurses knew." E32 stated, "I didn't feel that staff could handle it (when) he would wander. Anything stimulating was upsetting to him... No other resident on the unit was as aggressive as (R24)."

Review of the medical record showed that Z3, the Physician, ordered an injection of Ativan after the incidents on 8/23/06. According to the nurses notes dated 11/15/06, R24 was transferred to the local hospital after becoming physically aggressive toward staff. On the Emergency Room Report, the Physician, Z8, documented, "The patient is prone to unpredictable and fairly infrequent violent behavior." According to the report, R24's antipsychotic medication, Risperdal, was increased and R24 was returned to the facility with a diagnosis of "Violent Behavior." An Emergency Room Report dated 11/17/06 at 8:55 p.m. documents R24 was again sent to the local hospital after, "He apparently struck a resident and was physically aggressive towards staff.." Z3, R24's physician ordered additional Depakote and R24 was returned to the facility.

During interview with Z3, R24's Physician, on 1/09/07 at approximately 1:00 p.m., Z3 stated that he was unaware of R24's behavior history or sexually aggressive behaviors prior to R24 being admitted to the facility. Z3 and the office nurse, Z9, both stated that they were aware of R24's behavior pattern, stating that they received calls frequently. Z3, the Physician, stated that R24 was not appropriately placed at the facility. Z9 stated that Z3 had been trying to get R24 transferred for a "very, very, very long time."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145772	A. BUILDING _____ B. WING _____	01/17/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ODD FELLOW-REBEKAH HOME	**201 LAFAYETTE AVENUE EAST MATTOON, IL 61938**

(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 75 On the Care Plan dated 11/09/06, Problem (4) states "(R24) gets physically abusive 1 to 3 days/ week." The Short Term Goal is for R24 to "Exhibit physical aggression less than 1 to 3 days/ week." Some of the Approaches direct staff to: 1) Ensure (the) safety of others. 2) Divert (R24) away from problem area. 3) (One to one as needed with Social Service). 5) Assess for pain and 6) See psychiatrist." On the backside of the Care Plan under Problem 8. Falls, staff have documented one of the altercations involving (R24) dated 10/30/06. The Care Plan Approaches included: 1) (Continue with) 15 minute (checks). 2) (Continue) to attempt to involve (R24) in as many activities as possible. 3)Monitor for further (behavior), make sure (behaviors) are documented, monitor for (prescription) changes if behaviors (increase) or worsen 4) refer to (Social Service as needed to assist with behaviors). No other specific altercations or individualized Care Plan approaches have been documented on the Care Plan. Other than checking R24 every 15 minutes and non-specific attempts to involve R24 in Activities, the Care Plan did not contain any resident specific ability-oriented approaches for other members of the interdisciplinary team. In spite of continued physical altercations after 10/30/06, there is no documentation of alternate interventions attempted to ensure adequate supervision of R24 and prevent further altercations beyond medication adjustments. On 1/9/07 at 2:15 p.m., E1, Administrator was asked about staff's supervision of R24. E1 stated that there was not enough facility staff to provide 1:1 supervision. E1, Administrator, stated that she knew of R24's behaviors prior to admission	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145772	A. BUILDING _____ B. WING _____	01/17/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ODD FELLOW-REBEKAH HOME	201 LAFAYETTE AVENUE EAST MATTOON, IL 61938

(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 76 and that is why E1 thought R24 would be appropriate for the Alzheimers (a locked) unit with private rooms. (A) Section 300.7040e) Section 300.7040 Activities e) Activities shall be adapted, as needed, to provide for maximum participation by individual residents. If a particular resident does not participate in at least an average of 4 activities per day over a one-week period, the unit director shall evaluate the resident ' s participation and have the available activities modified and/or consult with the interdisciplinary team. This requirement was not met as evidenced by: Based on observation, the facility failed to engage 5 of 20 residents (R4, R6, R9, R29, R38) of the North Special Care Alzheimers Unit in meaningful activity during the 3 survey days of observations made on the unit. Findings include: Observations were made of R29 and R4 wandering aimlessly around the unit on 1-7-07, 1-8-07, and 1-9-07. R29 was making "crying" noises and "grunting" noises as R29 wandered around. R29 would occasionally sit down but usually only for a few seconds at a time. R29 would go to the exit doors and push against the exit doors' panic bar aggressively pushing against it until either staff directed R29 to move	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145772	A. BUILDING _____ B. WING _____	01/17/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ODD FELLOW-REBEKAH HOME	**201 LAFAYETTE AVENUE EAST MATTOON, IL 61938**

(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 77 on or R29 decided to move away. At times R29 would move chairs or tables and push the tables up against the wall. R29 was observed to push against chairs that other residents were sitting in at the time. R4 was observed to be wandering aimlessly around the unit most of the time without staff intervention. Occasionally staff would speak to R4 but staff did not try to engage R4 in anything other than to walk R4 into the Activity Room. R4 was observed to be placed in a recliner by staff who would then walk away leaving R4 with E28, Assistant Activity Director, who was conducting an activity that R4 would not participate in. R4 was not given anything to do when taken to the Activity Room, so R4 would not stay and would again be off walking in the halls. R4 was also identified to be going to the exit doors and pushing on the panic bar aggressively as well as pushing chairs. At 4:15 p.m. on 1-7-07, R4 walked unattended, over to the attached south wing of the special care unit and returned by staff only when (alarm signal) bell rang (by E15 at 4:15 p.m.) The Activity Plan for R4 dated 5-5-06 states "will encourage Resident to come to the activity room and try to get her to do a positive activity and watch for response." R38 was observed to usually/frequently stand next to the nurses station or near a staff person or other visitor on the unit. Staff allowed R38 to just stand near them without engaging R38 in any conversation or any activity during the three observation days. Similar observations were made of residents (including R6 and R9) not being engaged in activities and allowed to be sitting for long	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145772	A. BUILDING _____ B. WING _____	01/17/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ODD FELLOW-REBEKAH HOME	**201 LAFAYETTE AVENUE EAST MATTOON, IL 61938**

(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 78 periods of time, sleeping in the recliners, or staring off without any activity involvement from the staff. (B) Section 300.7070a)1)2)3) Section 300.7070 Quality Assessment and Improvement The unit shall have a written plan that is part of the facility ' s overall quality assurance plan to assess resident ' s quality of care, quality of life, and overall well-being. a) The licensee shall develop and implement a quality assessment and improvement program designed to meet at least the following goals: 1) Ongoing monitoring and evaluation of the quality of care and service provided at the facility, including, but not limited to: A) Admission of residents who are appropriate to the capabilities of the facility; B) Resident assessment; C) Development and implementation of appropriate individualized ability-centered treatment plans; D) Resident satisfactions; E) Infection control; F) Appropriate numbers of staff; and	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145772	A. BUILDING _____ B. WING _____	01/17/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ODD FELLOW-REBEKAH HOME	**201 LAFAYETTE AVENUE EAST MATTOON, IL 61938**

(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 79 G) Staff turnover 2) Identification and analysis of problems. 3) Identification and implementation of corrective action or changes in response to problems. These requirements were not met as evidenced by: Based on observation and interview, the facility failed to ensure that their quality assessment and assurance program took appropriate and necessary steps to identify and correct repetitious resident aggression/behavior and supervision problems on the Alzheimer's Special Care Unit for 3 of 4 months of the latter part of 2006 impacting at least 13 residents (R7, R10, R21, R23, R24, R25, R26, R29, R32, R36, R39, R40, and R41) on multiple documented occasions. The facility also failed to identify and offer solutions to correct quality issues through the established quality assurance program relating to lack of dining assistance and provision of activities on the Alzheimer's Special Care Unit. Findings include: Interview with E2, Director of Nursing on 1-11-07 at 2:45 p.m. reflected that while the facility has a Quality Assessment and Assurance Committee and program structure in place to assess and address quality issues within the facility, he stated he was unaware of formalized plans or directions put in place as prescribed by the Committee or Program to address serial aggression by R24 toward at least 12 other residents (R7, R10, R21, R23, R25, R26, R29,	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145772	A. BUILDING _____ B. WING _____	01/17/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ODD FELLOW-REBEKAH HOME	201 LAFAYETTE AVENUE EAST MATTOON, IL 61938

(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 80 R32, R36, R39, R40, and R41) on the Alzheimer's Special Care (Harmony) Unit since August 2006. Review of available documentation in the 13 residents' clinical records reflected evidence of multiple documented occurrences of physical aggression by R24 since his admission in August of 2006. E1, Administrator stated in interview on 1-11-06 at 5 p.m. that monthly quality assurance meetings are held in the facility with department heads. E2 stated that he was unsure how often quality assessment meetings are held. E2 stated that various departmental issues were discussed at the two meetings where he was present since August 2006. E2 stated that he was unaware of any formalized plans specifically put in place as a result of Quality Assessment and Assurance activities relating to the ongoing behavioral problems of R24. E2 further indicated that the facility has relied heavily on the involvement of Z1, R24's attending Physician/Facility Medical Director to assist in resolving this issue. Interview with E2 indicated that there is no evidence that the multidisciplinary Quality Assessment and Assurance Committee has fully assessed the ongoing problem or offered viable options/solutions to ensure proper behavior management/supervision of R24 so as to protect the health and safety of other vulnerable residents on the unit. E2 stated that written minutes of the meetings are kept but that he has never seen them since beginning his employment in August of 2006.	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145772	A. BUILDING _____ B. WING _____	01/17/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ODD FELLOW-REBEKAH HOME	**201 LAFAYETTE AVENUE EAST MATTOON, IL 61938**

(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 81 On 1/9/07 at approximately 2:00 p.m. E6, Social Service Director (SSD), was questioned about the facility Quality Assessment/Assurance (QA) committee. E6, SSD, stated that the Department Heads meet with the Administrator once a month to discuss problems in the facility. E6 stated that Quarterly QA meetings also included the Physician (Medical Director), Z3. E6, stated that Social Service has not received copies of the incident reports or reports of resident to resident altercations about R24 (A resident of the Alzheimer's Special Care Unit). E6 stated that he did not recall any monthly QA meeting when R24's behaviors were discussed. E6 stated that he brought up the issue of R24's behaviors at the last quarterly QA meeting after he heard about the incidents from "one of the Nurses". E6 stated that E1, Administrator, agreed that R24's behaviors were a problem. E6 stated that Z3, Physician, asked who the Psychiatrist was and stated that Z3 would call him. E6, SSD, stated that E1, Administrator called the Psychiatrist, Z7, the next day and was told that Z3 had not contacted Z7 yet. Interview with E5, Unit Director of Harmony Unit (Alzheimer's Special Care Unit), on 1-11-07 at 3:10pm shows that E5 attends the facility's monthly Quality Assurance Meetings with the department heads and the quarterly meeting with the Medical Director. E5 stated "I report how the unit is running and any complaints." E5 stated that he did not have any specific Quality Assurance (Q/A) monitoring tools or any Q/A studies for the Harmony Unit to identify any specific problems. E5 stated "Sometimes they (staff) just take the problems to the main building - to (E1,	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145772	A. BUILDING _____ B. WING _____	01/17/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ODD FELLOW-REBEKAH HOME	**201 LAFAYETTE AVENUE EAST MATTOON, IL 61938**

(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 82 Administrator). I don't hear all the problems that goes on over here." E5 was asked to identify who "they " were and E5 stated the nursing staff. E5 stated "resident behaviors are usually discussed by them (administration) over there (in main building) first, I don't get copies of all the Incident Reports so I don't know about all of them." Repetitious problems were identified during the survey with residents not engaged in activities for extended periods of time. Some residents were allowed to sit and stare or stand without anything to do. Other residents were allowed to wander aimlessly around the unit without purpose, showing frustration by banging on the panic door handles, pushing tables, and chairs. On occasion these residents were observed sitting down for a very brief few minutes/seconds or having staff direct them to sit down or go to the activity room. Another consistently identified problem during the survey was lack of dining assistance for residents. Residents who were to receive constant monitoring or assistance to encourage meal intake were not given the assistance necessary as identified in their individual program plans for safety. Some residents were not encouraged to eat but were allowed to sit and stare at the plate of food. (B)	F9999		