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

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		146043	B. WING			01/12/2007	
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP MANOR HEALTH CENTER			1	4	REET ADDRESS, CITY, STATE, ZIP CODE 85 SOUTH FRIENDSHIP DRIVE IASHVILLE, IL 62263	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 514	incident documented 11/21/06. E11 did DON, as a potential investigated. E11 swas a "sexual act". There is no documented investigated. There is no documented investigated. Operated additional incident 11/21/06. 1/11/07. E12 stated "patting each other" and that no sexual by either resident. E12, LPN, was 1/12/07 at 11:40 AM not reviewed her dotted that R21 had been E12 stated that she that the residents we E12 stated that she R7 on that date.	ge 25 ed in the Nursing Notes dated not report the incident to E2, I sexual abuse to be stated that she did not feel this umentation of any interviews 07 after the facility was a about potential sexual abuse on 1/12/07, E2 and E11 al information regarding the E11 had interviewed E12 on that R21 and R7 were s legs", not touching genitals comments were being made interviewed by telephone on M. E12 stated that she had ocumentation dated 11/21/06, transferred to another facility. It is did not recall documenting were "rubbing pubic region." It is did recall separating R21 and 12 stated she, "didn't feel that they (R21 and R7) were	F	514			
F9999	FINAL OBSERVAT		F9:	999			
	 a) The facility shall procedures, govern the facility which sh 	esident Care Policies have written policies and ing all services provided by all be formulated by a cy Committee consisting of at					
	Resident Care Police	cy Committee consisting of at					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
146043		B. WING			01/12/2007			
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP MANOR HEALTH CENTER				4	REET ADDRESS, CITY, STATE, ZIP CODE 85 SOUTH FRIENDSHIP DRIVE IASHVILLE, IL 62263			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ACTION SHOULD BE FO THE APPROPRIATE		
F9999	least the administrathe medical advisor representatives of a the facility. These pwith the Act and all thereunder. These followed in operating reviewed at least at evidenced by writte of such a meeting. Section 300.650 Ped The facility shall applicants with the hiring. Section 300.660 Na (a) A facility shall not nurse aide unless to Department as to inconcerning the indicate Act) The Departif the individual is on has findings of abut misappropriation of Sections 3-206.01 at the individual has a (See Section 300.660). These requirement by: Based on interview failed to follow their residents from abus Nursing Assistant (abuse on the State failied to follow their failing to follow their residents from abus Nursing Assistant (abuse on the State failied to follow their failing to fail failing to f	ator, the advisory physician or by committee and hursing and other services in policies shall be in compliance rules promulgated written policies shall be ag the facility and shall be annually by this committee, as an, signed and dated minutes be resonnel Policies check the status of all Nurse Aide Registry prior to aursing Assistants at employ an individual as a she facility has inquired of the aformation in the Registry vidual. (Section 3-206.01 of the the Registry, if the individual se, neglect, or a property in accordance with and 3-206.02 of the Act, and if a current background check.	F9	999				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	JLTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUIL	DING	·		
		146043	B. WING		01/12/2007		
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP MANOR HEALTH CENTER			:	48	EET ADDRESS, CITY, STATE, ZIP CODE 5 SOUTH FRIENDSHIP DRIVE ASHVILLE, IL 62263		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHO		JLD BE	(X5) COMPLETION DATE
F9999	and not checking reemployers. The fact status on the Health to employment. Eto on 8/28/06 as a nur was enrolled in the at the facility to become the facility to become the facility to become the facility to the facility for all Certification (CNA's) employed by "Administrative Finnoted on E6's HCV information also not in a Certified Nurse 11/20/06 with compand 11/20/06. E1, Administrator, which is the facility to the facility of the facility of the facility of the facility to the facility of the facility	Health Care Worker Registry) eferences from previous cility failed to check E6's h Care Worker Registry prior s was employed at the facility rse assistant. On 10/20/06 E6 Certified Nurse Aide program come a Certified Nurse Aide. d on 11/17/06 when E6 re facility further failed to check orker Registry for 6 additional des (E14-E19) prior to their Nurse Aide Roster" provided e surveyors was checked Care Worker Registry" tified Nurse Aides	F999	99			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SURPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			(X3) DATE SURVEY COMPLETED	
		146043	B. WIN	G		01/1:	2/2007
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP MANOR HEALTH CENTER				48	EET ADDRESS, CITY, STATE, ZIP CODE 85 SOUTH FRIENDSHIP DRIVE ASHVILLE, IL 62263		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	E6 began employme E6 continued to wo when she was term "Separation and Diemployee file contable Background Check The background chonon-disqualifying "In been convicted for Property" on 7/28/9 documentation in the been checked. E6 Employment did not contareference checks pure The facility's "Abus states, "This facility individuals who have neglecting or mistrefurther states that the abuse the facility will not know staff with a finding also states "Prior to work schedule, this reference check from accordance with far Health Care Worked being hired for a Central Care worked to the continued of th	was reviewed and identified lent at the facility on 8/28/06. rk at the facility until 1/9/07 linated according to the scharge" form. The lined a Criminal History which was done 8/20/06. leck identified E6 did have a lit" which indicated E6 had "Criminal Damage to 19. There was no le file that the HCWR had so "Application For lot identify that E6 had CNA. E6's employment lein any documentation of	F99	999			

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AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		146043	B. WING		01/12/2007		
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP MANOR HEALTH CENTER				4	REET ADDRESS, CITY, STATE, ZIP CODE 85 SOUTH FRIENDSHIP DRIVE NASHVILLE, IL 62263		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	all applicants will be to the extension of screen will include more supervisors, a registry and validat references. The powill be extended an work history could a disqualifying offens licensure cannot be convictions on the Neither policy was 2. On 1/9/07 employed checked against the additional CNA's; E19, who were idented the CNA registrest, stated that they registry at time of history at t	e appropriately screened prior the employment offer. The reference checks with one or status check on the CNA ion of work history and/or plicy also states no applicant offer of employment if the not be validated, there are es on the CNA registry, a validated, or there are Criminal background check.	F99	999			