STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145388	A. BUILDING _____ B. WING _____	C 10/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHLAND CARE & REHAB	**410 EAST MACK OLNEY, IL 62450**

(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 490	Continued From page 13 d) Quality Assurance (QA) to be conducted by Administrator or the Director of Nurses. The results will be referred to the Medical Director at the quarterly QA meeting or relayed to the Medical Director monthly if needed.	F 490		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.3240a)b)c)d)e) 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 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) 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	F9999		

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F9999	Continued From page 14 disciplinary action against the employee. (Section 3-611 of the Act) These Requirements were not met as evidenced by: Based on record review and interview, the facility failed to provide an environment free of abuse for one resident (R2) who was physically and verbally abused by one staff member (E6) on 10/15/06, and facility staff (E3) failed to promptly report this abuse. In addiiton, the facility's Director of Nurses (E12) and another nurse (E8) failed to begin an abuse investigation after being notified about the abuse. These failures allowed E6 to have direct patient contact for all residents in the facility for the remainder of the shift on 10/15/06, 10/16/06 ,10/17/06 and 10/18/06, putting all residents in the facility at risk for these dates. The facility also failed to investigate allegations by one resident (R3) that E6 yells at R3. In addition, the facility's Assistant Director of Nurses (E2) failed to report an allegation of verbal abuse by E6 to R2 that occurred approximately one year ago. Findings include: 1. E2 (RN, Assistant Director of Nurses) stated on 10/23/06 at 10:05 am, that on 10/20/06, E3 (CNA) reported to E8 (RN) that she had witnessed an abuse occurring on the evening shift on 10/15/06, and involving R2 and E6. E3 stated on 10/23/06 at 10:15 am, that she works the day shift but on 10/15/06 she worked the evening shift also. E3 stated that R2 had been in the dining room on this evening and became verbally abusive requiring staff to remove R2 to his room. E3 stated R2 fell from the wheelchair	F9999		

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F9999	Continued From page 15 while in room and E6 (LPN), E4 (CNA), E5 (CNA) and E3 responded. E3 stated E6 told R2 "I'm not picking up dead weight...get up." E3 stated E6 was behind R2 and put her arms under R2's arms pulling backwards. E6 also had a knee in R2's back. E3 stated R2 yelled out with E6's knee in the his back. E3 stated E4 and E6 then transferred R2 to bed. E3 also stated that after leaving R2's room, E6 stated in the hall, "I just can't stand that man." E3 stated R2 did not hear the comment. E3 stated the incident was not reported to anyone except another CNA until E3 reported to E8 (RN) on 10/19/06. [On at] E8 stated he reported the incident to E12 (Director of Nurses) and E2 (Assistant Director of Nurses) on 10/20/06 at approximately 10:00 am, E1 (Administrator) stated on 10/23/06 at 9:00 am that he had no knowledge of the allegation until presented by surveyor. Interview with E2 on 10/23/06 at 10:05 am indicated no investigation had been initiated. E12 verified on 10/23/06 at 2:20 pm that no investigation had been done. Review of the work schedule indicated E6 had worked the remaining shift on 10/15/06, and the evening shifts on 10/16/06, 10/17/06 and 10/18/06. R2's Assessment of 07/28/06 indicated R2's cognition is severely impaired and R2 requires extensive assistance of two for transfer. Interview with E2 indicated R2 has behaviors of verbal abuse, resisting care and inappropriate sexual behavior. Surveyor attempted to interview R2 on 10/24/06 at 10:00 am. R2 could not recall the incident. R2 could not state where he lived, the day, and time of the week. 2. R3 stated on 10/23/06 at 1:45 pm that E6 "yells" at him. R3 stated his blood sugar	F9999		

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F9999	Continued From page 16 fluctuates greatly. R3 stated "one morning the blood sugar was 73 and (R3)was shaky." R3 stated E6 wouldn't give him anything with sugar, "told me no..you are all right." R3 stated he knows how he feels and he needed something. R3 stated E6 :"just yells no." Interview with E7 (LPN) stated on 10/23/06 at 11:45 am that R3 had reported to her that E6 had yelled at him. A written statement was provided to surveyor by E7 indicating R3 had reported this mistreatment (verbal) by E6. During interview on 10/24/06 at 1:00 pm, E2 verified R3 had concerns regarding E6 "yelling ." E2 stated a "concern" form was filled out and E2 spoke with R3. No abuse investigation was conducted. 3. Interview with E1 on 10/26/06 by phone, E1 indicated (through phone interview) that an allegation of verbal abuse occurred approximately one year ago involving R2 and E6. E1 stated while R2 was dressing, R2 became verbally abusive stating "put on my F---socks." E6 responded to R2 by saying "put on your own F---socks." E1 stated E2 verbally reprimanded E6 at that time. E1 stated (E1) had no knowledge of the incident until 10/26/06 during facility staff interviews. This incident was verified by E2 on 10/30/06 at 10:45 am and E17 (CNA) on 10/30/06 at 11:00 am. Review of the facility's Abuse Prohibition Policy (undated) indicated "every employee is obligated to report any incident or suspicion of abuse....to a department head or the Administrator ...immediately." (A)	F9999		