STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145414	A. BUILDING ______ B. WING ______	C 01/11/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHABBONA HEALTHCARE CENTER	**WEST COMANCHE ROAD** **SHABBONA, IL 60550**

(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
F 323	Continued From page 4 for these residents. 3. On 11/04/05 wedge bolsters arrived from supply company. Bolsters were placed on beds identified as a safety risk and bath blanket rolls were removed. 4. Routine monitoring was done per maintenance, and will be ongoing. The Director of Nursing and Administrator to ensure that these corrective measures were maintained. 5. An inservice was done on 12/22/05 at 2:00 PM for all staff to educate as to the proper use of side rails and safety measures. 6. On 12/21/05 all residents were assessed for the need for side rails. Maintenance ws given a list of those residents who did not use side rails and told to remove the rails completely. Maintenance began measures immediately. Care Plan coordinator began updating care plans and nursing assistant cardex on each resident to ensure information is available to all staff. This was completed on 12/21/05.	F 323		
F9999	FINAL OBSERVATIONS Licensure Violations 300.1210a) 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	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145414	A. BUILDING ______ B. WING ______	C 01/11/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHABBONA HEALTHCARE CENTER	**WEST COMANCHE ROAD SHABBONA, IL 60550**

(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	Continued From page 5 resident to meet the total nursing and personal care needs of the resident. 300.1210b)4) Personal care shall be provided on a 24-hour, seven-day-week basis. 300.1210 b)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. 300.3240a) AN OWNER, LICENSEE, ADMINISTRATOR, EMPLOYEE OR AGENT OF A FACILITY SHALL NOT ABUSE OR NEGLECT A RESIDENT. (Section 2-107 of the Act) Based on observation, record review and interview the facility failed to ensure that one resident's side rails were free of accident hazards . R2 was found entrapped between the side rail and the mattress on 10/30/05. This applies to 1 bed of 11 in the facility with a large space between the mattress and the side rail affecting R2. The findings include: R2's Physician's Order Sheet dated December 2005, documents R2's diagnoses to include Cerebral Palsy, Seizure Disorder, Mental Retardation, and Legally Blind. R2's Minimum Data Set (MDS) Assessment of 9/29/05 assessed R2 as having short and long term memory impairment, and having severely	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145414	A. BUILDING ______ B. WING ______	C 01/11/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHABBONA HEALTHCARE CENTER	**WEST COMANCHE ROAD** **SHABBONA, IL 60550**

(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	Continued From page 6 impaired cognitive skills for daily decision making . R2 was assessed as being totally dependent on one person for bed mobility and transfer. R2 was assessed as being unable to attempt the test for balance without physical support. R2 has limitations in range of motion on both sides including arm, hand, leg, and foot. Partial voluntary movement loss was assessed to include R2's neck, hand, leg and foot. R2 was assessed as using two full bed rails. The document entitled Side Rail Assessment shows that the last progress note was written on 9/29/05. R2 used a reclining chair with a lap cushion, R2 has no body control, poor balance, no purposeful movement, and is manually lifted to a chair. There was no reassessment following the incident of 10/30/05 in which R2's head became entrapped between the side rail and the mattress. Occurrence report dated 10/30/05 at 10:10 PM documents that "R2 was found with his head stuck between the mattress and the rail. The rest of his body was laying on the floor on the right side of his bed. Side rail taken off while supporting his head and then lowered to the floor ." Nursing Notes for 10/30/05 at 10:10 PM documented that the Nursing Assistant said that R2 was laying on the floor, but his head was stuck between the rail and the mattress on the right side of his bed. R2 was covered in feces from his feet to his waist. Some of the feces was dry on the floor. The rail was taken off while R2's head was held and R2 was lowered to the floor. The notes do not describe how long R2 had been	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145414	A. BUILDING ______ B. WING ______	C 01/11/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHABBONA HEALTHCARE CENTER	**WEST COMANCHE ROAD** **SHABBONA, IL 60550**

(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	Continued From page 7 in that position. On 10/31/05 at 2:15 AM the nursing notes show that R2 was found with bruising to the right and left knees. There was no documentation of an assessment following the occurrence on 10/30/05 documented. R2's Potential for Injury Care Plan dated 1/15/05 through 9/29/05 does not reflect R2's potential risk factors for becoming lodged in between the side rails and the mattress. On 12/20/05 at 12:30 PM, E2(DON) stated that R2 gets agitated and can get his legs through the side rails. E2 was also interviewed on 12/20/05 at 12:40 PM. E2 stated that R2 gets agitated when having a bowel movement and moves about the bed. On 12/20/05 at 1:00 PM. E3 (LPN) said she was the person responsible for the Quality Assurance meetings. E3 said that the issue of side rail safety had not been discussed in the Quality Assurance meeting because the Medical Director was out of town at the time. E3 said there are no other residents here who thrash around in bed like R2 does. On 12/19/05 at 11:55 AM R2 was observed lying in his bed, making unintelligible sounds. R2 did not respond to verbal interaction. R2's hands, arms and legs were observed to be in flexion contractures. On 12/20/05 all the beds in the facility were observed. Sixty-six of 91 beds were observed to have side rails. Eleven of 66 beds were	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145414	A. BUILDING ______ B. WING ______	C 01/11/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHABBONA HEALTHCARE CENTER	WEST COMANCHE ROAD SHABBONA, IL 60550

(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	Continued From page 8 observed to have gaps either between the head of the bed and the start of the side rails or gaps at the foot of the bed and the end of the side rails. The gap ranges were from 4 inches to 19 inches. These rooms included: 2,4, 6, 7, 9, 16, 21, 24, 25, 41, 50. (A)	F9999		