STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145937	A. BUILDING _____ B. WING _____	C 02/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW NURSING PLAZA	**321 ARNOLD AVENUE ROCKFORD, IL 61108**

(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 323	Continued From page 7 2. Residents who use side rails will be reviewed for continued use. This began on 2/19/07 and will be completed by 3/2/07. 3. Staff will be inserviced on side rail safety and use (Completed on 2/21/07). 4. Staff were inserviced on call light placement (Completed 2/2107). 5. Any resident who has side rails in place and actively attempts to climb out of bed will be re-assessed to ensure proper plan of care is in place (Completion date 3/2/07). 403 bed 1 and 2 and 406 were replaced.) 6. The side rail assessment was reviewed and revised on 2/20/07. 7. A Quality Assurance Monitoring tool was developed to ensure side rail monitoring and record reviews related to side rail use. Information will be reviewed at QA meetings (2/20/07). 8. A bed safety policy was initiated (2/21/07). 9. The side rails similar to R1's (3/4 design) have been replaced (2/21/07).	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210b)6) 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
	145937	A. BUILDING _____ B. WING _____	C 02/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW NURSING PLAZA	**321 ARNOLD AVENUE ROCKFORD, IL 61108**

(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 8 Nursing and Personal Care 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. This REGULATION is not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide an environment free from accident hazards by not ensuring that: 1. Bed rails did not have spaces large enough for residents to become lodged in between the bed rails and the bed frame. 2. Bed rails were properly fitted to beds according to manufacturer's specifications. 3. Side rails were not loose. On 2/19/07 at 3:25 AM, R1 was discovered wedged between his bed frame and his side rail. R1 was positioned in a manner that occluded his airway. R1's head was resting on the floor, and his chin was resting on his chest. R1's shoulders were on the floor, and his lower torso was on the bed. R1 was unresponsive, pulseless, and without respirations. R1 expired from positional asphyxiation according to the County Coroner. This applies to 1 of 14 residents with side rails on their beds (R1).	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145937	A. BUILDING _____ B. WING _____	C 02/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW NURSING PLAZA	**321 ARNOLD AVENUE ROCKFORD, IL 61108**

(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 9 Findings include: R1's Physician's Order Sheet for February 2007 documents that R1's diagnoses included Diabetes mellitus and Chronic Obstructive Pulmonary Disease. R1's Physician Order Sheet for January 2007 shows an order on 1/8/07 for 2 side rails to be up. The facility Admission record of 1/8/07 shows that R1 has old bruise around right eye due to fall prior to admission. R1's Nursing Notes for 1/8/07 at 2:15 PM show that R1 arrived at the facility by stretcher and was placed in bed with 2 side rails up. The same note documents that R1 had a history of falling, mainly out of bed because he forgets to use the call light for assistance to go to the bathroom. R1's Minimum Data Set (MDS) assessment of 1/16/07, done for a significant change, assessed R1 as having no short or long term memory problems, but moderate cognitive impairment is coded. (R1's decisions poor, cues/supervision required). The same assessment shows that R1 requires limited assistance of one person for bed mobility, transfer, and toilet use. R1's range of motion was limited on one side, with partial loss of voluntary movement. This included R1's arm, hand, leg, and foot. R1's assessment does not identify the use of side rails as a mode of transfer. Side rails are not identified as a device or a restraint. R1 had an unsteady gait and daily moderate pain. There are no accidents identified. R1's Falls Resident Assessment Protocol (RAP)	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145937	A. BUILDING _____ B. WING _____	C 02/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW NURSING PLAZA	**321 ARNOLD AVENUE ROCKFORD, IL 61108**

(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 10 review dated 1/16/07 documents: R1 has an unsteady gait and is under the influence of psychotropic medications. R1 is at risk for falls. Two side rails are being used when R1 is in bed. R1's Side Rail Assessment dated 1/16/07 documents that R1 was using his side rails for bed mobility. The same document shows that R1 had no history of falls. R1's MDS assessment of 1/21/07 (Medicare 14-day initial assessment) assessed R1 as having a short and long term memory problem with moderately impaired cognitive skills. The assessment does not identify the use of side rails as a mode of transfer, nor as a device or restraint. No accidents were identified on this assessment. A hospital transfer record dated 1/24/07 documents that R1 is a high risk for falls and should have his side rails up. The same document shows that R1 has left arm weakness and right arm paralysis. R1 has bruising on his face and legs from falls prior to hospitalization. An Incident Report dated 1/31/07, at 1:30 PM, documents that R1 was found on the floor in the door way of his bathroom. It is documented that R1 reported getting dizzy and falling. Nursing Notes for 2/14/07 document that R1 was found on the floor near his bed. R1 stated he did not know what happened. R1's Nursing Notes for 2/19/07 at 3:25 AM document R1 was discovered on the floor of his room. R1's head was fully flexed with his chin on	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145937	A. BUILDING _____ B. WING _____	C 02/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW NURSING PLAZA	**321 ARNOLD AVENUE ROCKFORD, IL 61108**

(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 11	F9999		

his chest. His buttocks and legs were on the bed. R1 was in a supine position (facing upward), and the side rails were across R1's waist.

R1's Falls care plan of 2/4/07 documented that R1 has weakness and syncope (dizziness). The care plan does not identify R1's cognitive impairment, behavior of getting out of bed without assistance, or the use of side rails. Specific interventions for R1's risk factors are not documented on the care plan.

A statement (no date) written by E6 (Certified Nursing Assistant / CNA) shows that when E6 went to answer a call light, she looked into R1's room and saw a chair tipped over. E6 went into R1's room and saw R1's head and shoulders on the floor, and she called to E5 (CNA). E6 and E5 removed the side rail to get R1 onto the floor.

E5 (CNA) was interviewed on 2/21/07 at 4:15 PM. E5 said she was called by E6. E5 said she went to R1's room and saw his head down on the floor. E5 said the back of R1's head was resting on the floor, the side rail was against R1's pelvis area, and R1's legs were partially on the bed. R1's arms were down at his sides. E5 said that "R1 was always getting out of bed and complaining of being dizzy. I told him to put on his call light. R1 could not use his right arm and could only use his left arm a little. He would scoot to the end of the bed and get out all the time."

On 2/21/07 E1 (Administrator) was interviewed at 1:35 AM. E1 said that R1 had side rails for bed mobility, and that R1 had a history of getting out of bed without assistance.

On 2/2/1/07 at 1:50 PM, E1 used R1's previous

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145937	A. BUILDING _____ B. WING _____	C 02/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW NURSING PLAZA	**321 ARNOLD AVENUE ROCKFORD, IL 61108**

(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 12	F9999		

bed and side rails to demonstrate R1's body position on 2/19/07. E1 positioned himself between the bed frame and the side rail, with his head and shoulders on the floor, and his legs partially on the bed. E1 confirmed that R1's chin was resting on his chest. Measurements were taken of R1's side rails at this time, and they were found to have an 8 inch gap between the edge of the bed frame ad the side rail. The length of the side rail was 47 inches. The side rail was attached at the center of the bed frame on both sides of the bed. E1 demonstrated how R1 would scoot himself to the foot of the bed and get out between the space between the foot board and the end of the side rail.

On 2/21/07 at 3:55 PM, E1 was asked if he had any product information or specifications on the side rails. E1 said that there was no product information available on the side rails. E1 said that they had fitted the side rails to the beds the best they could.

Z4 was interview on 2/26/07 at 1:15 PM. Z4 said that he was told that R1 tried to squeeze out of his bed. Z4 said "R1 got caught in the side rail and choked off his air. R1 was unable to use his right arm, and his left arm was very weak. R1 tried to get out of bed at the foot of the bed before. We were called by the coroner's office, and (they) told us that R1's air got cut off and that is what he died from."

All side rails in use in the facility were observed on 2/21/07 beginning at 2:00 PM.

The following residents were observed to have side rails on their beds: R2 - R14. E2 (Director of Nursing) and E4 (Nurse Consultant) were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145937	A. BUILDING _____ B. WING _____	C 02/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW NURSING PLAZA	**321 ARNOLD AVENUE ROCKFORD, IL 61108**

(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 13 present during the unit tours and bed observations. Room 303 (R10): 2 full side rails were observed to have a 9.5 inch space at the end of the side rail to the foot board. Room 306 (R2): Two one-half style side rails were observed. There was a 8.5 inch space between the middle rails. Room 307 (R11): A full style bed rail was observed to be loose on the left side of the bed. Room 403 (R5): Two 3/4 style side rails were observed. The side rail on the left side of the bed was loose. Room 2507 (R13): Two full side rails were observed on the bed. A mat was observed on the floor. R13 was in a regular bed. E4 said that R13 is blind and had not fallen out of his bed for a while. Review of incident reports for R13 showed: On 12/28/06 R13 rolled out of bed and hit the side of his head. On 12/21/06 R13 was found in his room lying on the floor. On 1/9/07 R13 tipped his mattress out of the bed frame and landed on the floor. Review of the facility policy and procedure entitled Proper Use of Bed Rails shows the following: Page 9, item 8)c. Less restrictive interventions the facility might incorporate: include placing the bed lower to the floor and surrounding the bed with a soft mat.	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145937	A. BUILDING _____ B. WING _____	C 02/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW NURSING PLAZA	**321 ARNOLD AVENUE ROCKFORD, IL 61108**

(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 14 Page 10, item 9). If less restrictive approaches are not successful, then the facility must document this and obtain orders to apply and monitor the use of bed rails for a specific period of time. Item 11). The resident should be checked frequently for safety. (A)	F9999		