STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145817	A. BUILDING ______ B. WING ______	C 02/09/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HOUSE OF CENTRALIA	**1000 MARTIN LUTHER KING DRIVE CENTRALIA, IL 62801**

(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 324	Continued From page 3 E1(Administrator) and E2(Director of Nurses) on 2-8-07 at 10:45 AM. The Immediate Jeopardy was determined to have begun when the bolster device was not appropriately applied to the bed on 1-29-07. The Immediate Jeopardy was removed when R3 was admitted to the hospital on 1-29-07, and when the other bolsters were removed from all other residents bed. The facility took the following steps to remove the Immediate Jeopardy: 1. E2(Director of Nurses) reassessed all the bolsters to R3, R5, R6, and R7 on 1-29-07. 2. E2 removed the bolsters from R3, R5, R6 and R7's bed on 1-29-07. 3. Administrator, E1 conducted an in-service for 19 certified nurses aides on 2-7-07 regarding adequate supervision, safety, communication sheets to report change of condition of a resident, and proper positioning . 4. Quality Assurance determined that no bolster will be used in the facility on 2-5-07. 5. Reassessment of all assistive devices for proper functioning and usage done on 2-9-07. 6. Bed heights were reassessed for proper height on 2-9-07. 7. The Quality Assurance Committee will monitor all residents for safety. This is ongoing.	F 324		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.1210a) 300.1210b)6) 300.1220b)2)3) 300.3240a) Section 300.1210 General Requirements for	F9999		

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F9999	Continued From page 4 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. 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. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 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	F9999		

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F9999	Continued From page 5 orders, and personal care and nursing needs. 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These Requirements were not met as evidenced by the following: Based on record review and interviews, the facility failed to provide properly applied bed bolsters for one of three residents (R3) assessed to utilize bed bolsters as positioning devices. This failure resulted in R3 falling from the bed and receiving an intracranial hemorrhage and a laceration to the forehead. Findings include: R3's fall assessment form dated 11-06, shows this 93 year old resident was assessed to be at high risk for falls. The side rail assessment screening tool dated 11-16-06, identified that R3's two padded side rails were discontinued, and two bed bolsters were put into use. The facility's incident report dated 1-29-07, shows that R3 was found laying on the floor next	F9999		

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F9999	Continued From page 6 to the bed with her bed bolster having flipped off the side of the bed. R3 was noted to have a deep laceration to the left side of her forehead. The facility's investigation shows that R3 attempted to scratch her buttock, and "rolled all the way over bed bolster to floor." However, staff interviews obtained during the investigation show that staff reported that the bolster was found on the floor next to R3. A confidential interview conducted on 2-7-07 at 2:22 PM, shows that R3's bolsters were not applied appropriately. On the night of 1-29-07 R3's bolster device was not strapped under the bed. The bolster strap was put under R3's air mattress, and there were no Velcro straps used to hold the bolster on. This confidential interviewee also identified that R3's bed was in the high position at the time of the fall. E14(certified nurses aide/CNA who cared for R3) also identified on 2-6-07 at 2:45 PM, that R3's bed was usually in the high position. A review of the ambulance report dated 1-29-07, shows that when ambulance personnel arrived R3's bed was raised up to about 36 inches. E14, and E15(CNA's) stated on 2-6-07 that the bolster strap on R3's bed was placed under her air mattress and not the bed frame. E8 stated on 2-6-07 at 2:00 PM, that the last time she had seen R3's bed bolster attachment under the bed, it was tied below the bed or under the frame because of a missing latch or mismatched piece. E15 stated that when she would move R3 the bolster would also move. Interviews with E16(nurse), E17(nurse), E14, E15, and E8(CNA) also show that R3 would move a lot, or scoot down in the bed a lot. E13 (Therapy Manager) reviewed R3's assessment for the use of the	F9999		

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F9999	Continued From page 7	F9999		

bolster device dated 10-23-06. E13 stated that the evaluation indicated the use of the bolsters while in bed or in the reclining chair were for bilateral lower extremity positioning so that the bolsters would be used to rest body parts.

A review of the manufacture's procedure for the application of the bolster device shows the following steps that were omitted with the application of R3's bolster device on 1-29-07:
Step 2. Bring the end of the strap under and around the upper part of the bed frame. Feed the strap through the slider. Tighten the strap, making certain that the bolster is positioned near or at the edge of the mattress.
Step 3. Thread the Velcro strap attached to one bolster through the d-rings at the back of the opposite bolster. Bring the straps over the bolster and thread them through the d-rings at the back of the bolster. Take up any slack in the Velcro strap and secure them by pressing the hook material against the loop material.

The hospital emergency room record dated 1-29-07 identified that R3 sustained a laceration to the left forehead which measured 4 centimeters in total length, and that the laceration was "V" shaped. The laceration required sutures. The non-contrast cat scan of the brain showed an acute intracranial hemorrhage high in the left parietal lobe consistent with a parenchymal hemorrhage. The hemorrhage measures 3.5 centimeters by 2.7 centimeters with effacement of the sulci in the left parietal lobe.

According to E2, R3 is still currently in the hospital due to the accident.