©EPAR	FORI	PRINTED: 09/11/2007 FORM APPROVED OMB NO. 0938-0391							
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
145906			B. WI	NG		07/	C 07/19/2007		
	PROVIDER OR SUPPLIER			1	T ADDRESS, CITY, STATE, ZIP (CODE			
LEE CO	UNTY NURSING & RE	HAB CTR			ON, IL 61021				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F 323	Continued From pa	ge 6	F	323					
	Manager will ensur special equipment upon hire.	tursing or other Department e new staff are in-serviced on used in their departments							
	new equipment with	or will eview the monitoring of the Quality Assurance other recommendations or							
F9999		ent will be assembled and manufacturer's guidelines.	F9:	999			:		
	LICENSURE VIOLA	ATIONS							
	300.1210a) 300.1210b)3) 300.1210b)6) 300.2410a) 300.2410b)								
; ; ;	Nursing and Persor a) The facility must and services to atta practicable physical well-being of the res	seneral Requirements for the last Care provide the necessary care in or maintain the highest mental, and psychological sident, in accordance with aprehensive assessment and							
:	plan of care. Adequ nursing care and per to each resident to a personal care needs measures shall included following procedures	ate and properly supervised rsonal care shall be provided meet the total nursing and softhe resident. Restorative ude at a minimum the							

minimum the following and shall be practiced on

a 24-hour, seven day a week basis:

PRINTED: 09/11/2007 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 145906 07/19/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **800 DIVISION STREET** LEE COUNTY NURSING & REHAB CTR **DIXON, IL 61021** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETION PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F9999 Continued From page 7 F99991 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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 300.2410 Furnishings a) Each resident shall be provided with a separate bed suitable to meet the needs of the resident. Each bed shall be at least 36 inches wide, have a headboard, be of sturdy construction and in good repair. A double bed shall be provided for married couples, if they request this arrangement, and there are no medical contraindications. b) Each bed shall be provided with satisfactory type springs in good repair and a clean, firm, comfortable mattress of appropriate size for the bed. These Requirements are not met as evidenced by the following: Based on observation, interview, and record review the facility failed to ensure that a new bed was safe for resident use by not: (1) Ensuring that the head and foot boards were installed on the

bed based on the length of the mattress to prevent entrapment, (2) Ensuring that all attaching hardware on the bed was securely tightened before putting it in use, and (3)

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING C B. WING 145906

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LEE COUNTY NURSING & REHAB CTR DIXON, IL 61021					
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 8 Instructing direct care staff on the operational guidelines for the bed prior to placing the mattress on the bed. On 7/12/07 these failures contributed to R1's head becoming entrapped between the bed frame and the head board, requiring extrication by the local Fire Department. This applies to 1 resident (R1) who was placed in a new motorized high low bed for safety beginning 5/23/07. Findings include: R1 has diagnoses of Alzheimer's Disease, Anxiety, Dysphagia, Osteoporosis, Convulsions, and Psychosis per the undated Admission Record. The Minimum Data Set (MDS) of 5/7/07 documents that R1 has both short term and long term memory deficits and is severely impaired in his ability to make decisions. R1 is totally dependent on staff for all activities of daily living. R1's Care Plan dated 7/13/07 documents that R1 is a total assist of 1 to 2 staff for bed mobility. The facility's Incident Report dated 7/12/07 documents that facility staff found R1 at 4:30 AM with his head tucked under the headboard of his bed. Facility staff immediately notified the local Fire Department for assistance in safely removing the headboard from R1's bed. The last time staff saw R1 was when they provided care at 2:30 AM positioning him on his back in the middle of his bed. The City Fire Department Run Sheet dated 7/12/07 shows that Emergency Medical Services was dispatched at 4:58 AM and arrived at the facility at 5:02 AM. The City Fire Department Run Sheet states, "On arrival met nursing staff in R1's	F99	999	DETICIENT)	

PRINTED: 09/11/2007

07/19/2007

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

PRINTED: 09/11/2007 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUILDING			С	
	145906		B. WING			07/19/2007	
NAME OF PROVIDER OR SUPPLIER LEE COUNTY NURSING & REHAB CTR				81	REET ADDRESS, CITY, STATE, ZIP CODE 00 DIVISION STREET DIXON, IL 61021		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	SHOULD BE COMPLETION	
	room who were trying between headboard frame, which was uposits low to floor Parown with snoring research had vomited and (R1) unable to commexisting medical condisassembled the moved the bed out. On 7/17/07 at 10:30 interview, Z1 (Parant 15 minutes to get Richardboard was uposite was touching the floagainst the steel frame of the behave snoring respiration the bed. Once we and got him on the costopped. The mattre not bunched up or sl. Nurses wanted him to emergency room for vomiting. Staff was cobleed. R1 is a Hospid nurse did not want his back into his bed and A written statement of (LPN) verifies that the stated in her report to gap. E5 (CNA) provistatement concerning statement concerni	and his mattress and bed p against the wall. R1's bed tient (R1) breathing on his spirations, R1 had good color. If it was dark in color. Patient municate with crew due to aditions. Ambulance crew eadboard from the frame and from the wall to free R1" AM, during a phone nedic) stated, "It took us 10 to 1 extricated from the bed. The against the wall. R1's forehead or and his neck was up me of the bed. The up against the back of R1's 8 to 10 inch gap between the ed and the headboard. R1 did ations while he was entrapped extricated R1 from the bed sot the snoring respirations ss was flat on the bed. It was hifted in any way. The facility to be transported to the evaluation related to his concerned R1 may have a Glice patient and the hospice im sent out. We assisted R1	F99	999			
1				- 1			

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

PRINTED: 09/11/2007 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
1459		145906	B. WING			C 07/19/2007	
NAME OF PROVIDER OR SUPPLIER LEE COUNTY NURSING & REHAB CTR				800	ET ADDRESS, CITY, STATE, ZIP CODE DIVISION STREET CON, IL 61021	077	372001
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX		CROSS-REFERENCED TO THE APPROPRIATE		
		AM E1 (Administrator) was delivered to the facility					

PRINTED: 09/11/2007 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING C B. WING 145906 07/19/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **800 DIVISION STREET** LEE COUNTY NURSING & REHAB CTR **DIXON. IL 61021** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F9999 Continued From page 11 F9999 on 5/23/07 fully assembled. E1 said that the mattress used on the bed measured 79 inches. E1 was not aware if any adjustments or modifications were made to R1's bed. E1 was asked if nursing staff had been in-serviced on the safe operation of R1's new motorized high low bed and E1 responded "Not that I am aware of." The facility was unable to provide any information showing that staff had been trained on the importance of headboard placement in relation to

The Proration And Maintenance Manual for the motorized high low bed states, "Do not operate this equipment without first reading and understanding this manual. If you are unable to understand the warnings, cautions, or instructions, contact a health care professional or a qualified technician before using this equipment. Otherwise injury or damage may result." On page 3 of the Operation and Maintenance Manual under warnings it states. "After installation and before use, make sure all attaching hardware is securely tightened." On page 6 of the Operation And Maintenance Manual under installation it states that if the bed length (mattress) is 76 to 80 inches the headboard should be in bracket hole B. If the bed length (mattress) is 84 inches the headboard bracket should be locked in hole C. When the headboard bracket is locked in hole C there is a 8 inch gap between the bed frame and the headboard.

the size of the mattress being used on the bed. The facility did not have a policy and procedure on the implementation/maintenance of new

patient care equipment.

(A)