STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145395	A. BUILDING _____ B. WING _____	C 10/11/2007

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REHAB & CARE CTR - JACKSON CO	1441 NORTH 14TH STREET MURPHYSBORO, IL 62966

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F 323	Continued From page 17 interdisciplinary team for immediate review and/or resolution of individual resident issues. Nursing Administration will compile a quarterly analysis of side rail data for review by the quality Assessment and Assurance committee. Completion date: 10-07-07 E. A memo was sent to all supervising nurses/charge nurses on October 8, 2007 updating staff on the changes in the policies and procedures relating to side rails and side rail assessments.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.682a)1 300.682a)2 300.1210a) 300.1210b)6) 300.3240a) Section 300.682 Nonemergency Use of Physical Restraints a)1)The assessment of the resident's capabilities and an evaluation and trial of less restrictive alternatives that could prove effective; a)2) The assessment of a specific physical condition or medical treatment that requires the use of physical restraints, and how the use of physical restraints will assist the resident in reaching his or her highest practicable physical, mental or psychosocial well being; Section 300.1210 General Requirements for Nursing and Personal Care	F9999		

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a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental or 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 resident to meet the total nursing and personal care needs of the resident.

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.

300.3240 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)

These REGULATIONS were not met as evidenced by:

Based on observations, interviews, and record review, the facility failed to identify that the use of 1/2 side rails constitutes a safety hazard and failed to implement effective interventions to prevent falls for one resident of five in the sample. R1 had 4 falls from the bed with the last fall resulting in R1's neck being wedged between the 1/2 side rail and the mattress. This avoidable accident caused R1 to sustain neck and jaw bruising, a skin tear, soreness, and a one cm indentation on her jaw line.

The facility identified 118 residents from a census

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of 131 residents as using side rails while in bed. The facility also identified 100 residents as needing assistance of one or two staff for transferring and 10 residents were identified as totally dependent on staff for transferring.

Findings include:

1. R1 has been a resident in this facility since 10-18-01 according to R1's face sheet. According to the October 2007 Physician's Order Sheet, R1 has diagnoses of Senile Dementia with Agitated Features, Osteoporosis, Osteoarthritis, and Profound Deafness.

The most recent Minimum Data Set (MDS) for R1 dated 07-29-07 documents that R1 has short-term and long-term memory problems, poor decision making skills, periods of restlessness, sometimes can make self understood, and sometimes has the ability to understand others. This MDS also documents that R1 needs extensive assistance from one person for bed mobility, transfers, and toilet use.

The side rail assessment tool for R1 dated 1-13-07 and reviewed 07-20-07 indicates 1/2 side rails are used at all times when resident is in bed for assistance with bed mobility and bed transfers.

The facility's fall risk assessment for R1 dated 07-25-07 indicates that R1 has a history of falls, her gait and transferring ability is impaired, and her mental status is such that she forgets limitations. On this facility tool, high risk is scored as a 45 and higher. These deficits give R1 a score of 75.

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R1 was found on the floor as follows.

A. The facility incident report for R1 dated 06-18-07 at 3:20 am documents that R1 was found sitting on her buttocks on the floor of her room with the 1/2 side rails up on both sides of her bed. There was a 0.5 cm abrasion noted on her coccyx. R1 stated that she hit the back of her head and that she was getting up out of bed.

B. The facility incident report for R1 dated 07-03-07 at 3:00 pm documents that R1 was found sitting on the floor of her room with her legs turned to the left and bent with her back against the bed. R1 complained of right hip/buttocks pain which was relieved when legs were straightened. A 1.5 cm by 0.7 cm red abrasion was found on her right knee. E13, Certified Nurses Aide, who responded to the bed alarm, found R1 on the floor. The facility incident/accident investigative report documents that when asked what happened, R1 stated, "OOO, I slid off the bed." This report also states that R1 was attempting to go to the bathroom and the 1/2 side rails were up at the time of the incident.

After the above two incidents of being found on the floor, a facility repeat incident/accident follow-up report was completed on 07-05-07. The area on this form to address environmental or situational hazards of recent incidents states "(Body) alarm recently added to alert staff when res (resident) attempts up out of chair/bed." This form also stated, "Care plan appropriate at this time."

R1 was moved to a room closer to the nursing station on 07-20-07 as documented on the repeat incident/accident follow-up report dated 08-07-07.

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The room change note dated 07-20-07 documents this room change and gives the reason for the room change as "No longer requires pvt (private) room, need room for res (resident) with behavior issues."

C. The facility incident report for R1 dated 09-16-07 at 9:25 PM documents that R1 was found lying on the floor of her room with feet on top of the trash can. R1 had a 4 cm by 3 cm red area to her left upper back. The incident/accident investigative report documents that R1 said she was "trying to get in that chair" and also documents that the 1/2 side rails were up. An employee statement form is attached to this investigation completed by E12, CNA. E12 documented in her statement that she, "Heard resident in room screaming about her brothers and asking for help. I went in resident room to check on her and found res on the floor. Her head was positioned at the foot of the bed and legs on the other end on top of her trash can."

D. The facility incident report for R1 dated 09-26-07 at 12:40 am documents that E8, CNA, heard R1 yelling "Help me" and called E9, Registered Nurse, to the room. E9 documented in the incident report and the nurses note for 09-26-07 at 12:40 am that R1 was observed sitting on the floor on her buttocks with her head leaned back on the bed and her neck lodged in the side rail under bottom bar between the rail and the mattress. R1 was noted to have a red line on her jaw and left side of her neck, a 1 cm indentation to the right jaw line which was slight purple and red, her neck was red, and there was a 3 cm skin tear to the top right hand. E9 was interviewed on 10-04-07 at 9:20 am over the telephone and also at 12:50 pm on that date. E9

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verified that R1 was sitting on the floor with her neck between the side rail and the mattress. E9 stated that she pulled the side rail out while supporting R1 to get her out of the side rail. E9 stated that R1 had her hands down at her side with a sheet and bedspread wrapped around her body. E9 described R1 has being excited and E9 had to calm her down. E9 said that R1 could not move nor could she understand what was going on. During this interview, E9 stated that R1 can help turn herself.

A bed bolster to R1's bed was ordered on 09-26-07 after the fall according to the September 2007 physicians order sheet. There was no assessment of the risks versus the benefits found for this device. This was verified during the daily status on 10-04-07 by E2, Director of Nurses.

R1 was observed on 10-04-07 at 2:55 pm in bed. A body alarm was attached to her right shoulder and to the far right side of the head board which would allow her to move off the bed before alarming. There was also a cushioned bolster attached to the edge of the bed impeding R1's exit from the bed. It was three feet long and positioned in the center along the side of the mattress with 1 1/2 feet of space at the head and also at the foot of the bed. This bolster was 6 inches high.

On 10-05-07 at 9:00 am, R1's bed was observed to be a low profile bed with a mat beside the bed. There was a sensor pad on the bed. This change was verified by E1 during the daily status meeting at 2:35 pm on 10-05-07.

E2 was interviewed on 10-3-07 and stated that the side rails are used by R1 for repositioning and

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turning. E2 stated that falls are looked at monthly and every 90 days to review repeat occurrences. When asked about other alternatives tried for R1, E2 stated she had not tried a low profile bed because R1 is combative with care and can assist at times, but E2 did think maybe a hi-low bed might work. E2 stated the facility had two functioning hi-low beds that were in use by other residents and before buying a new hi-low bed would have to justify it by trying alternative measures.

E7, Restorative Registered Nurse, stated during an interview on 10-03-07 at 2:10 pm that there is a yearly review of side rails and if residents use them for positioning or transfers, they leave them alone. She also stated that if there is a problem with the side rail such as an arm or leg caught in one, the side rail will be removed or a wedge rail cushion will be put in place to prevent reoccurrence.

E6, Assistant Director of Nurses, stated during an interview on 10-03-07 at 1:25 pm that R1 would grab the rail herself as staff would turn her to give care. E7 stated on 10-03-07 at 2:10 pm that R1 will use the side rail to grab on to and help hold herself over during care. This was verified by E2 during the daily status meeting on 10-04-07 at 1:25 pm.

(A)