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	145628	A. BUILDING _____ B. WING _____	C 06/24/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN NURSING & REHAB CENTER	**1115 NORTH WENTHE EFFINGHAM, IL 62401**

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F 323	Continued From page 11 between the mattress and siderail. E8 stated she pushed R1's siderail back in some times 10 times before it caught. E8 stated if you barely touched the siderail or lower the rail they would easily push out. E8 stated this occurred at least one time a shift when she cared for R1. E8 felt R1 could push the siderail out if she leaned against the rail caused from forceful coughing. E8 stated she reported this to a nurse around Christmas 2009 (not sure to who) and no changes were made and R1's siderails as they continued to "pop out". E8 reported Z1 told her he had asked for R1 to get new siderails in the past and he seemed upset. E8 stated she did not see any pads on R1's siderails on 06-06-10 prior to 7:00PM. E8 also stated she had seen R1's face very close to the left siderail in the past after she positioned resident to the left side. E8 stated the bed siderail do not protect R1's top half. E8 stated R1 is turned every 2 hours and positioned with pillows with the head of her bed elevated 60 degrees. R1 coughs forcibly and pitches her torso forward observed by E8 at times.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)6) 300.2210a) 300.2210b)5) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest	F9999		

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F9999	Continued From page 12 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 300.2210 Maintenance a) Every facility shall have an effective written plan for maintenance, including sufficient staff, appropriate equipment, and adequate supplies. b) Each facility shall: 5) Maintain all furniture and furnishings in a clean, attractive, and safely repaired condition. Section 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 requirements are not med as evidenced by: Based on observation, record review and	F9999		

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F9999	Continued From page 13 interview the facility failed to identify, report and/or correct an observed environmental entrapment hazard regarding siderail use for one of four residents on the sample (R1). The malfunction of the full length telescoping siderail crossbar system caused a 6 inch gap from the mattress to the rail resulting in R1 getting her lower abdomen caught on the siderail crossbar and falling from the bed. R1 was sent to the emergency room and sustained skin irritation and mental anguish. The facility identified 20 to 21 resident beds in the facility with the full length telescoping siderail crossbar system in place. Seventeen residents occupy these beds with the siderail system and were potentially at risk for entrapment with the use of this type of siderails. These residents are R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, and R18. Finding include: 1. R1 was admitted to the facility on 12-08-01 according to the admission face sheet. The June 2010 physician's order sheet states R1's diagnoses include: Cerebral Vascular Accident with left hemiparesis, Dysphagia, Seizures, Muscle Spasm and Alzheimer's Disease. According to R1's Annual Minimum Data Set Assessment (MDS) dated 04-16-10, R1 is severely impaired for cognitive skills for decision making. R1 was also assessed to require total dependence of two or more staff for bed mobility, manually lifted transfers, dressing and bathing. R1 has functional limitation in range of motion for both hands, arms, feet and legs with partial loss of voluntary movement identified on the MDS assessment. The MDS does not identify any	F9999		

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F9999	Continued From page 14 devices or restraints used for R1. The "Side Rail Assessment" form used by the facility updated 04-15-10 states no changes since 02-09-09 in the use of padded side rails for patient safety. The assessment states resident is not able to get in/out of bed unless complete total lift with assist of 2 caregivers. It also states resident is severely impaired physically/cognitively with history of seizures. The assessment does not identify what type or the number of side rails to be used and when. A "Restraint Assessment" dated 10-21-09, states R1 has side rails up x 2 for boundary identification, and a laptray when up in wheelchair for positioning. A check mark on the assessment was noted stating "This resident is totally dependent on staff for transfers and bed mobility and does not ambulate. Bed rails(s) are used to prevent involuntary movement and falls from bed, therefore bed rails(s) are not considered a restraint." There was no mention that R1 was assessed for entrapment potential with the use of the siderails and laptray, or R1's involuntary movement. R1's care plan, dated 04-22-10, states R1 is at risk for falls related to ADL deficit, involuntary movements due to history of seizures, need for total assistance for transfers/positioning, and is to have siderails padded and up x 2 for boundary identification and to facilitate bed mobility and lap tray when up in chair for positioning. An intervention for falls states to do "periodic inspection of all equipment for safety measures." R1 was observed on 06-15-10 at 12:13PM resting in bed with both full siderails elevated. R1 is fed per gastromy tube. R1 was unable to	F9999		

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F9999	Continued From page 15	F9999		

move her self in bed voluntarily and is aphasic. R1's head of the bed was elevated approximately 30 degrees and splints were observed on her left leg and arm. R1 was observed to cough with force and move her upper torso forward in bed. On 06-13-10 at 3:04PM, R1 was transferred with 2 person assistance (E12 and E13-CNAs) with a full lift (non weight bearing) from the bed to the wheelchair. R1 was observed to be incontinent of urine and stool.

According to the facility's "Investigation Report" dated 06-06-10 at 7:23PM, R1 was found by family lying across her bed with her head on the floor. The occurrence report states R1 had red areas on the crown of her head, on her left forearm, and across the middle of her abdomen. According to the nurses notes dated 06-06-10 at 7:20PM by E6 (LPN), E5 (LPN) heard Z1 yelling and proceeded to R1's room. E5 observed R1 "halfway out of bed with head touching floor, resident buttocks and legs in bed." E5 repositioned R1 "back into bed and noted siderail in place but extended out from proper positioning (measured 6 1/2 inches)." R1 was assessed and noted a red discoloration of abdomen, right arm and to top of head. R1's physician was notified and orders were received to send to the emergency room to evaluate and treat, according to the nurses note 06-06-10 at 7:30PM. According to the 06-06-10 nursing notes R1 returned to the facility at 11:00PM after having a CT scan of the head and cervical spine. The hospital report dated 06-06-10 stated no acute intracranial hemorrhage, no recent fracture or acute bone injury.

According to interview with Z1 on 06-15-10 at 2:25PM, he found R1 on 06-06-10 at 7:25PM

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F9999	Continued From page 16 lying with her front lower abdomen on the metal side rail crossbar with her head flat on the floor. R1's feet, legs and buttocks were still on the bed. R1's left arm was by her side and the right arm across her chest. Z1 stated the left full side rail on R1's bed was "popped out approximately 12 inches and R1 was caught between the bed mattress and left top siderail of her bed." Z1 stated he called for help, and E5 and E6 (Licensed Practical Nurses) and E7 and E8 (Certified Nursing Assistants) responded. Z1 stated R1's bilateral bed rails were raised but no side rail pads were on the bed. Z1 stated R1's face was red with a large amount of secretions on her face and a puddle of urine on the floor close to the middle of the bed. Z1 also stated there was a daily occurrence of R1's side rails coming unhooked from R1's bed frame and the spring would pop the side rail out. Z1 stated he had reported this to the nurse and the nurse had written a report. When questioned who and when he reported this to, he was not sure. Z1 stated the bed rail was never fixed as far as he knew. Per interview with E5 on 06-16-10 per phone on 2:55PM, she was the first person to respond to Z1's call for help. When E5 entered R1's room between 7:00 and 7:30PM, R1 was found with her head touching the floor and her lower 1/2 of her body in bed (right hip and right buttocks were elevated). E5 stated R1's left upper side rail was unhooked from the bed frame and the side rail was pushed out from the mattress about 6 inches. According to E5, R1 was caught between the siderail and mattress with her abdomen across the siderail cross bar. E5 picked R1 up and placed her back in bed. R1 was assessed by E5 and red areas were noted on her head, left	F9999		

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F9999	Continued From page 17 forearm and across her stomach. R1's face was red and a large amount of moist secretions were on her nose, forehead, and hair. A urine puddle was noted on the floor toward the bottom of R1's bed R1 seemed scared because she is not able to move herself according to E5. E5 stated R1 has only involuntary movements and often coughs violently propelling her upper body forward. Per interview with E3 (Maintenance Supervisor) on 06-15-10 1:55PM, E3 stated the facility has approximately 20 to 21 beds in the facility with full length telescoping siderails with a cross bar that goes under the mattress and hooks into the bed frame. The long rails then connect into the crossbar apparatus. The side rails or crossbar are not permanently fastened to the bed frame. E3 stated R1's siderails and other residents' siderails with this system have come unhooked from the bed frame prior to R1's 06-06-10 fall. E3 stated he was able to push the crossbar back into the frame. E3 states the siderails come unhooked when staff bumps or hits the siderail/crossbar connection. No modifications were made with this type of full side rail telescoping system by E3 until 06-07-10. E3 demonstrated how the side rails can become unhooked from the bed frame and the spring loaded crossbar projects 5 1/2 inches leaving a gap from the mattress to the long siderail. E3 stated on 06-15-10 at 1:55PM, he was currently in the process of ordering new brackets for these type of siderails to be bolted to the bed frames for the 20 beds the facility currently has with these type of long siderails. E1 (Administrator) stated on 06-15-10 at 2:30PM, currently 17 residents occupy these beds with the full length telescoping siderails with the cross bar system.	F9999		

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F9999	Continued From page 18 Per surveyor observation on 06-24-10 at 1:20PM, R1's bed was observed with E1. R1's siderail measured 50 inches and the top was positioned 8 inches from the top of the mattress. R1's bed frame measured 34 inches and the total length of a crossbar measured 39 inches with brackets that the siderail fit into. R1's mattress measured: length 79 inches and width 36 inches. Per interview with E7 (CNA) by phone on 06-16-10 at 1:50PM, she has cared for R1 since she started on 12-01-09. E7 states R1 has no voluntary movement but propels her upper torso forward when she coughs forcibly and is unable to move back to former position. E7 stated she is 5'3" in height and she has bumped against R1's siderails several times resulting in the rails extending out 4 to 6 inches beyond the mattress. E7 stated she reported this to a nurse and maintenance staff was summoned to fix the rails. E7 stated other residents' siderails have had this same problem with the siderails extending 6 inches out from the mattress - R4 specifically. E7 stated when she observed R1 on 06-06-10 at 7:00PM, both long siderails were elevated and not extended out from the mattress, and no pads were noted on the siderails at that time. During interview with E8 (CNA) by phone on 06-16-10 at 2:12PM, E8 stated she had a problem R1's left and right siderails "popping out from the bed frame all the time." This left a space of 6 inches between the mattress and siderail. E8 stated she pushed R1's siderail back in sometimes 10 times before it caught. E8 stated if you barely touched the siderail or lowered the rail they would easily push out. E8 stated this occurred at least one time a shift when she cared	F9999		

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F9999	Continued From page 19 for R1. E8 felt R1 could push the siderail out if she leaned against the rail caused from forceful coughing. E8 stated she reported this to a nurse around Christmas 2009 (not sure to who) and no changes were made to R1's siderails as they continued to "pop out." E8 reported Z1 told her he had asked for R1 to get new siderails in the past and he seemed upset. E8 stated she did not see any pads on R1's siderails on 06-06-10 prior to 7:00PM. E8 also stated she had seen R1's face very close to the left siderail in the past after she positioned resident to the left side. E8 stated the bed siderails do not protect R1's top half. E8 stated R1 is turned every 2 hours and positioned with pillows with the head of her bed elevated 60 degrees. R1 coughs forcibly and pitches her torso forward as observed by E8 at times. (A)	F9999		