STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146064	A. BUILDING _____ B. WING _____	C 12/17/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN MANOR	2650 NORTH MONROE STREET DECATUR, IL 62526

(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 6 having foot boards in place10/22/09) 9. Maintenance bolted all removal footboards to the beds. 12/11/09 10. Staff not at prior inservices were educated on the footboards. 12/15/09	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210b)6) 300.2210b)5) 300.3240a) 300.1210 General Requirements for 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. 300.2210 Maintenance b) Each facility shall: 5) Maintain all furniture and furnishings in a clean, attractive, and safely repaired condition. 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 met as evidenced	F9999		

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F9999	Continued From page 7 by: Based on record review, interview, and observation, the facility failed to maintain 7 of 7 beds in a safe condition. Seven beds were not equipped with foot boards. These beds had exposed sharp metal brackets which were potentially hazardous for the 7 residents (R2) who used these beds. R2 tipped his wheelchair over and fell hitting the exposed metal rail that houses the foot board. This fall caused a large penetrating laceration to the R2's neck. R2 required hospitalization for surgical repair of the laceration. R2 died eight days later. Findings include: The POS (Physicians Order Sheet) for R2 dated 10/28/09 states diagnosis of Dementia. Nurses notes for R2 dated 10/17/09 document: "Monthly Summary. Resident will be resistive to care and have disruptive behaviors. Resident will calm with staff intervention." The care plan for R2 dated 07/29/09 states, "High fall risk due to dementia and osteoporosis. Has a history of previous falls." This care plan states R2 is to have lap cushion when in wheelchair and is to be in a low bed with a mat on the floor. Falls risk assessment for R2 dated 07/29/09 states, "High risk for falls." MDS (Minimum Data Set) for R2 dated 07/22/09 documents resident has short term memory problems, difficulty making decisions, needs assistance of 2 persons for transferring and ambulation, and has fallen in the last 30 to 180 days. Incident report for R2 dated 10/20/09 at 2:35PM states, "Resident flipped while in wheelchair and landed on the end of beds metal frame foot rail	F9999		

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F9999	Continued From page 8 that penetrated resident's left neck region. CNA then at that time lifted resident's head from bed frame and lowered resident to floor and called for help." Nurses notes for R2 dated 10/20/09 state, "Resident was on the floor. Staff member was in room to begin providing care when resident became resistive. Resident used feet to push back wheelchair causing staff member to lose balance and fall into resident's recliner. At same time resident flipped wheelchair toward foot of bed hitting neck region on metal foot frame that penetrated residents left neck region causing a large open wound with bleeding. Staff member assisted resident by lifting head and neck from object and lowering resident to the floor. Physician was notified and resident sent to emergency room at hospital." On 12/10/09 at 3:15pm E5 CNA (Certified Nurse Aid) stated, "After (R2) knocked me over into the recliner, (R2) tipped the wheelchair over at the foot of the bed and landed on (R2's) left side. (R2's) neck hit the rail that the foot board hooks onto. There was no foot board attached to the bed. I had to lift (R2's) head off the rail because of the bleeding. Then I yelled for help." On 12/10/09 E1 (Assistant Administrator) stated, "There was no foot board on (R2's) bed. It was basically an oversight. We have a variety of beds here and many had no foot boards. It was my understanding that (R2) hit the foot of the bed where there was no foot board. I don't have a record of the beds that were without foot boards. I know we ordered 7 foot boards but I don't know what beds they went on."	F9999		

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F9999	Continued From page 9	F9999		

On 12/10/09 at 2:20PM E6 (Maintenance Supervisor) stated, "I went around that day (10/20/09) and replaced foot boards on several beds. Those that we didn't have foot boards I put soft cushioned tubing on the exposed parts at the foot of the bed. I don't remember who the other residents were that did not have foot boards in place at that time."

On 12/10/09 at 2:00PM E6 (Maintenance Supervisor) stated, "This is the bed like (R2) had." E6 then removed the foot board from the bed. Removal of the foot board from the bed exposed a metal bracket which extends out from the foot of the bed in an "L" shaped fashion.

The hospital Surgical Report form dated 10/20/09 by Z1 (Surgeon) stated R2 received an extensive left sided neck laceration that was 8 to 10 centimeters in length. R2's laceration started at the left lower jaw penetrating the parotid gland missing the facial and carotid arteries, then extending up through the back of the throat and lacerating a portion of the muscle, then through the oral cavity into the floor of the mouth and tonsil region. R2 also received lacerations of the lip and left ear.

Nurses notes for R2 dated 10/28/09 at 2:45PM state, "(R2) arrived by ambulance from hospital. Breathing is very labored and congested. Large neck wound on left side of neck closed with stitches. Periods of apnea noted up to 2 minutes (in length)." Nurses notes for R2 dated 10/29/09 at 4:15PM state, "Resident ceased to breathe. No pulse palpable. No lung sounds. Family at bedside. Hospice notified."

On 12/15/09 at 11:30AM Z1 (attending physician

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F9999	Continued From page 10 for R2) stated, "(R2's) medical condition was pretty stable up to the point of the accident. I would certainly think that this accident contributed significantly to (R2's) death. The resulting trauma inhibited (R2's) ability to swallow. The family opted for no feeding tubes and (R2) died shortly thereafter." Facility policy titled Maintenance of Building including furnishings provided on 12/11/09 at 10:50PM stated, "Spend time weekly checking the following items so that each resident room is checked on a monthly rotation: electrical outlets, plumbing fixtures, closet doors, draperies, door alarms, floor surfaces, drapery rods, and beds." On 12/11/09 at 12:50PM E1 (Assistant Administrator) stated, "We have had this policy for several years. I don't know exactly how old it is." On 12/10/09 at 2:00PM E1 (Assistant Administrator) stated, "We do a daily Total Quality Management meeting. We discussed (R2's) accident the day after it happened but by that time many of the foot boards had been put back on. For those beds that did not have foot boards available we placed soft cushioned tubing over the rail that stuck out from the bed frame where the foot boards went." On 12/11/09 at 11:00AM E6 (Maintenance Supervisor) stated, "I go around on a weekly basis and check all the beds to make sure foot boards are in place." On 12/10/09 at 10:30 AM the bed for R4 did not have a foot board in place. The end of the bed had two brackets that were "L" shaped and exposed at the foot of the bed. There was no	F9999		

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F9999	Continued From page 11 padded cushion covering the exposed sharp brackets. The resident room was empty with no staff present. The resident's bed was made. The facility Roster Matrix dated 12/10/09 states that R4 is cognitively impaired. On 12/10/09 at 11:50PM E1 stated, "We will have that foot board put back on." On 12/10/09 at 11:50 E2 (Director of Nursing) stated, "The staff removed it to provide care and forgot to put it back on." On 12/11/09 at 10:00AM E3 (Quality Control Nurse) stated, "The staff know the foot boards are to be on the beds. If they take them off like for cares they are to put them back on the bed before leaving the room." (A)	F9999		