STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145985	A. BUILDING _____ B. WING _____	C 01/11/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY NURSING & REHABILITATION	**UNIVERSITY DRIVE EDWARDSVILLE, IL 62025**

(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 7 seen on the most inferior slices of the study and only incompletely see." R1 also had a "large developing superficial hematoma overlying the right frontal bone". There was no intracranial bleeding noted. R1 was transferred to a large metropolitan hospital. The "Clinical Resume" from the large hospital stated that neurosurgery consult was obtained and recommended three options of treatment for R1 which included surgery, external fixation or a "J-Miami collar". The family opted for the collar and "palliative measures with hospice". R1 did not return to the facility and was transferred to another facility.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)6) 300.1220b)3) 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 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)6) All necessary precautions shall be taken to	F9999		

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F9999	Continued From page 8 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: 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 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 month 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 Regulations were not met as evidenced by: Based on record review and interview, the facility failed to provide supervision to prevent accidents for 1 (R1) of 3 residents reviewed. This failure resulted in R1 falling and sustaining a cervical	F9999		

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F9999	Continued From page 9	F9999		

fracture which required hospitalization, and then palliative care with hospice was pursued after the hospital stay.

The findings include:

R1 has diagnoses, in part, of dementia, osteoporosis, diabetes mellitus, and cerebral vascular disease. R1 was assessed on the 12/9/09 "Fall Risk Assessment" as high risk for falls.

The Minimum Data Set (MDS) dated 12/8/09 assessed R1 as moderately cognitively impaired. The MDS assessed R1 as requiring extensive assistance of 2 persons to transfer.

The care plan dated 12/18/09 identified "Falls" as a problem due to weakness, unsteady gait, osteoporosis and decreased safety awareness. The care plan identified as interventions as the bed alarm to alert staff, half side rails to maximize independence with bed mobility, and ensure residents safety during transfers. The care plan also identified side effects such as dizziness, vertigo, and gait disturbance from psychoactive medications as possible problems for R1.

E2 (Director of Nursing) confirmed on 1/11/10 at 10:25 AM that on 12/31/09 at 6:30 AM R1 fell from bed after E5 (Certified Nurse Aide) left her sitting up on the side of the bed unattended. E2 stated that E5 had put the half side rails down, took the alarm off of R1, and then left.

According to the Incident Report dated 12/31/09, R1 fell out of bed and hit the right side of her head causing a large "goose egg" on her forehead. R1 was put back into bed by staff. E2

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F9999	Continued From page 10	F9999		

stated she came in about 7:30 AM and immediately called for an ambulance after assessing R1. E2 stated that she was not sure when the physician was notified of the fall.

E2 stated that the nurse E7, had the CNA E5, do the neurochecks which were incomplete. E2 stated E7 should have done the neurochecks. E2 stated that E7 should have called 911 and sent R1 out immediately with a head injury. E2 confirmed that both E5 and E7 were suspended after the incident and both resigned.

E8 (Certified Nurse Aide) stated on 1/11/10 that she was in the room of R1 assisting her roommate. E8 stated the curtains were pulled between the residents and she could not see R1. E8 stated that she heard a loud crash and found R1 on the floor. E8 confirmed that the alarm was not sounding, and the rails were not up. E8 stated that E5 had been in the room but was not in there when R1 fell. E8 stated E5 had not told her she was leaving. E8 stated R1 had a knot on her head.

Review of the "Incident/Accident Report dated 12/31/09 completed by E7 noted that the incident occurred at 6:30 AM. E7 indicated on the report that the physician was not called until 7:30 AM. E7 did not document in the nurses notes about the incident.

Review of the "Neurological Assessment Flow Sheet" dated 12/31/09 for R1 noted that at 6:30 AM R1 was drowsy with sluggish left eye pupil response and unable to check the right eye. There were no observations documented. The right hand grasp was stronger than the left. At 7:00 AM the results were the same except the

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F9999	Continued From page 11 blood pressure and pulse had increased. The physician was not notified until 7:30 AM. R1 left the facility at 8:30 AM by ambulance. The "Resident Transfer Form" dated 12/31/09 noted that "neuro checks WNL (within normal limits)". R1 was sent to the local hospital emergency room where a computed tomography (CT) scan was done and found "multiple fractures involving the C1 ring both anteriorly and posteriorly. There appears to be fractures of the C2 spinous process as well. However, these fractures are seen on the most inferior slices of the study and only incompletely see." R1 also had a "large developing superficial hematoma overlying the right frontal bone". There was no intracranial bleeding noted. R1 was transferred to a large metropolitan hospital. The "Clinical Resume" from the large hospital stated that neurosurgery consult was obtained and recommended three options of treatment for R1 which included surgery, external fixation or a "J-Miami collar". The family opted for the collar and "palliative measures with hospice". R1 did not return to the facility and was transferred to another facility. (A)	F9999		