STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145631	A. BUILDING _____ B. WING _____	10/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWMAN REHABILITATION & HCC	**418 SOUTH MEMORIAL PARK DRIVE NEWMAN, IL 61942**

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F 000	INITIAL COMMENTS	F 000		
F 225 SS=D	Annual Licensure and Certification Survey 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified	F 225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	Continued From page 1 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to immediately remove perpetrators of alleged abuse after one allegation of abuse was reported to the charge nurse by R3, and a separate allegation to the Administrator on behalf of another resident, R5. R3 and R5 are two of three residents sampled for abuse from a total sample of eleven. Findings include: 1. The October 2011 Physician's Orders show R3 has diagnoses of Anxiety and Congestive Heart Failure. The August 2011 Minimum Data Set (MDS) indicates R3 is cognitively impaired, is not ambulatory, and requires assistance for all activities of daily living. An undated statement by E3 Registered Nurse reads as follows: "...I entered room (of R3) to give resident meds (medications) appro. (approximately) 5:45 AM (on 9/21/11), resident stated 'Thank God it's you and not the other one.' I asked her what she meant , she said, ' the other girl that's here now.' Then asked her why? Resident stated '...she's so rough, she just rips and tears and flips and flops like this...'resident was wringing sheet between her hands and rapidly flipping it up and down. I asked her if it was possible the other girl was just in a hurry and working rapidly, resident shook her head no and stated, '...no, I just don't think she likes me at all, I	F 225		

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F 225	Continued From page 2 don't feel like she has ever liked me..." The letter addressed to the State Survey and Certification Regional Office dated 9/22/11 reads as follows: "...On 9/21/11 it was reported to D.O.N. that the above named perpetrator (E4, Certified Nursing Assistant) had been accused of mistreating the above named resident (R3). Upon investigation, the resident made a statement to the night charge nurse that she felt like the accused perpetrator had mistreated her during morning care..." The time card of E4 dated 9/21/11 documents E4 clocked in at 4:57 AM and clocked out at 6:49 AM. The allegation was reported to the nurse at 5:45 AM. That computes to an elapsed time of 1 hour and 4 minutes that E4 was available to R3 and all other residents in the facility. The 11-4-10 Abuse Prevention Program, Facility Policy states, "...Employees of this facility who have been accused of mistreatment will be immediately removed from resident contact until the results of the investigation have been reviewed by the Administrator or designee. Employees accused of alleged mistreatment shall not complete their shift as a direct care provider to residents..." E1, Administrator stated on 10/5/2011 that the CNA should have been immediately suspended. E1 stated that before he (E1) became Administrator charge nurses did not have the authority to send subordinate staff home. E1 stated that at the present time the charge nurse does have the authority to "clock out" any accused offender.	F 225		

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F 225	Continued From page 3 2. On 10-4-11 at 2:00 p.m. R5 stated that she had experienced ongoing rough treatment by two Certified Nurse Aides (CNA). R5 stated at this time that E4 and E6 get her up most mornings and talk to her and handle her "roughly". R5 stated both staff jostle her and don't demonstrate much patience with her. This information was reported to the Administrator, E1 on 10-4-11 at 2:30 p.m. E1 stated on 10-5-11 at 4:00 p.m. that both alleged perpetrators, E4 and E6 worked the remainder of their shifts as direct care givers on 10-4 and most of their shifts the following day, on 10-5-11, before E1 removed them from the facility. E1 and E2, Director of Nursing stated on 10-7-11 at 10:50 a.m. that they did not recognize the reported "rough treatment" as being possible abuse and failed to act on it immediately. Both stated that R5 was not interviewed or questioned regarding the "rough treatment" allegation until the following day, 10-5-11. The 11-4-10 Abuse Prevention Program, Facility Policy states, "...Employees of this facility who have been accused of mistreatment will be immediately removed from resident contact until the results of the investigation have been reviewed by the Administrator or designee. Employees accused of alleged mistreatment shall not complete their shift as a direct care provider to residents..."	F 225		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315		

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F 315	Continued From page 4 Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to use proper technique during urinary catheter care by failing to keep the urinary catheter bag below the level of bladder while positioning R4, one of one resident sampled with urinary catheter in a sample of 11. Findings include: The Physician's Orders Sheet (POS) dated October 2011 lists the following diagnoses for R4: Overactive Bladder and the Physician's Telephone Order dated 8/28/11 has an order for R4 to have a 16 Fr (French) Foley catheter due to Urinary Retention and overflow incontinence. Change monthly. Foley catheter care every shift. E4 and E5 CNA's (Certified Nurse Assistants) on 10/5/11 at 9:40 AM during catheter care positioned R4 on to her right side. E5, removed the foley catheter drainage bag from the side of the bed and raised the drainage bag above R4's bladder to hand to E4 to position on the opposite	F 315		

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F 315	Continued From page 5 side of the bed to complete catheter care for R4. E4 repeated the same procedure when turning R4 to the left side by handing the drainage bag to E5 by lifting the foley drainage bag above the bladder and positioned R4 onto her left side. E5 on 10/5/11 at 9:55 AM stated that she did not realize lifting the foley drainage bag above the bladder could cause urinary tract infections. Facility policy titled "Urinary Drainage Collection Unit" dated 01/02 under the section title "Procedure" number 10 reads "Hang the urinary drainage unit below the bladder level..." R4's Nurses Notes dated 9/19/11 at 3:30 PM states R4 returned from the hospital with a new order for Levaquin for five days due to Urinary Tract Infection. Medical History report dated 9/19/11 from the hospital states under the section titled "Impression/Plan under # 1" reads "Febrile Illness with Urinary Tract Infection".	F 315		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 323		

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F 323	Continued From page 6 Based on observation, interview and record review, the facility failed to follow the plan of care to prevent falls for R1 and R5, two of 3 residents reviewed for falls, in the total sample of 11. R1 sustained a fractured pelvis, and R5 sustained a fractured right hip. Findings include: 1. Incident Investigation Report dated 09/24/11 at 6:20pm reports R1 removed the Nonrestrictive Alarm (NRA) attached to her shirt, stood up from her wheelchair, and fell in the dining room. The Post Fall Review dated 09/26/11 documents R1s history of removing the NRA. The report states " previous witness to (R1) unclipping a nonrestrictive alarm from her clothing, " R1 " forgets to take walker at times when up, " and ... " she is unable to remember to ask for assistance. " The Nurses ' Notes dated 09/23/11 (erronously per E2, DON, 10/06/11 at 3:00pm)document R1 was " found sitting on floor, feet straight out in front of her ...complains of pain in left knee. " R1 was transported to the hospital, x-rayed, and a pelvic fracture was diagnosed. The After Care Instructions from Provena Medical Center dated 09/24/11 at 11:00pm documents " Pubis Ramus Fracture. " The Minimum Data Set (MDS) dated 9/11/11 and 07/26/11 documents that R1's cognition is severely impaired, has short and long term memory loss, chronic confusion, and is dependent on staff for transfer and ambulation..	F 323		

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F 323	Continued From page 7 The Physician Order sheet(POS) dated 10/01/11 through 10/31/11 documents that R1 is an 89 years old with diagnoses of Alzheimer ' s Disease, Demented Illness with Associated Behavioral Symptoms, Depression, and Anxiety. The Fall Risk Assessment dated 07/22/11 documents R1 as high risk for falls with functional deficits in gait and balance including "loss of balance-standing, loss of balance-walking, and requires assist to stand." The care plan dated 09/18/11 documents that R1 is at risk for falls and potential for injury. The approach dated 09/18/11 states " Pressure alarm at all times. " On 10/07/11 at 10:50am, E2 acknowledged that a pressure alarm was not used on 09/24/11. E2 further stated that an NRA was used rather than the pressure alarm. R1's care plan included no assessed interventions for the use of the NRA. 2. The facility Incident Investigation Report for Falls dated 05/25/11 reports that R5 fell out of her wheelchair when reaching for her call light. On 10/06/11, E2, DON, reports E7,Certified Nursing Assistants (CNA) and E8, CNA brought E5 to her room after supper and left in her wheelchair unable to reach her call light. E2 also states R5 laid on the floor for an estimated 15 minutes before she was found by staff. The X-ray Report dated 05/26/11 reports " Impacted femoral neck fracture. "	F 323		

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F 323	Continued From page 8 The POS dated 10/01/11 through 10/31/11 documents that R5 is an 89 year old with diagnoses of Osteoarthritis and Parkinson ' s Disease. The Fall Risk Assessment dated 05/27/11 identifies E5 at high risk for falls. The Care Plan dated 03/17/11 documents R5 is at risk for falls and the following approach: " Keep call light within reach at all times. " The MDS dated 08/14/11 documents R5's cognitive ability as intact (Brief Interview for Mental Status, 14 out of 15). The MDS dated 08/14/11 documents R5 as needing only supervision and set up assistance with eating. On 10/04/11 R5 fed herself lunch without difficulty. On 10/04/11 at 2:00pm R5 demonstrated manual dexterity needed to use the call light by doing needlework indepently in her room. E2, DON, verified that E7, CNA, and E8, CNA left R5 ' s call light out of reach and were disciplined " for failure to leave call light in resident ' s reach. " The Job in Jeopardy document confirms E7 left " R5 without her call light in a comfortable position and within easy reach. "	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)5) 300.1210c) 300.3240a)	F9999		

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F9999	Continued From page 9 Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. b) The facility shall 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 resident care plan. 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. Restorative measures shall include, at a minimum, the following procedures 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan	F9999		

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F9999	Continued From page 10 Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. THIS REQUIREMENT IS NOT MET AS EVIDENCED BY: Based on observation, interview and record review, the facility failed to follow the plan of care to prevent falls for R1 and R5, two of 3 residents reviewed for falls, in the total sample of 11. R1 sustained a fractured pelvis, and R5 sustained a fractured right hip. Findings include: 1. Incident Investigation Report dated 09/24/11 at 6:20pm reports R1 removed the Nonrestrictive Alarm (NRA) attached to her shirt, stood up from her wheelchair, and fell in the dining room. The Post Fall Review dated 09/26/11 documents R1s history of removing the NRA. The report states " previous witness to (R1) unclipping a nonrestrictive alarm from her clothing, " R1 " forgets to take walker at times when up, " and ... " she is unable to remember to ask for assistance. " The Nurses ' Notes dated 09/23/11 (erronously per E2, DON, 10/06/11 at 3:00pm)document R1 was " found sitting on floor, feet straight out in front of her ...complains of pain in left knee. " R1 was transported to the hospital, x-rayed, and a pelvic fracture was diagnosed. The After Care Instructions from Provena Medical Center dated 09/24/11 at 11:00pm documents "	F9999		

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F9999	Continued From page 11 Pubis Ramus Fracture. " The Minimum Data Set (MDS) dated 9/11/11 and 07/26/11 documents that R1's cognition is severely impaired, has short and long term memory loss, chronic confusion, and is dependent on staff for transfer and ambulation.. The Physician Order sheet(POS) dated 10/01/11 through 10/31/11 documents that R1 is an 89 years old with diagnoses of Alzheimer ' s Disease, Demented Illness with Associated Behavioral Symptoms, Depression, and Anxiety. The Fall Risk Assessment dated 07/22/11 documents R1 as high risk for falls with functional deficits in gait and balance including "loss of balance-standing, loss of balance-walking, and requires assist to stand." The care plan dated 09/18/11 documents that R1 is at risk for falls and potential for injury. The approach dated 09/18/11 states " Pressure alarm at all times. " On 10/07/11 at 10:50am, E2 acknowledged that a pressure alarm was not used on 09/24/11. E2 further stated that an NRA was used rather than the pressure alarm. R1's care plan included no assessed interventions for the use of the NRA. 2. The facility Incident Investigation Report for Falls dated 05/25/11 reports that R5 fell out of her wheelchair when reaching for her call light. On 10/06/11, E2, DON, reports E7,Certified Nursing Assistants (CNA) and E8, CNA brought E5 to her room after supper and left in her wheelchair	F9999		

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F9999	Continued From page 12	F9999		

unable to reach her call light. E2 also states R5 laid on the floor for an estimated 15 minutes before she was found by staff.

The X-ray Report dated 05/26/11 reports " Impacted femoral neck fracture. "

The POS dated 10/01/11 through 10/31/11 documents that R5 is an 89 year old with diagnoses of Osteoarthritis and Parkinson ' s Disease.

The Fall Risk Assessment dated 05/27/11 identifies E5 at high risk for falls. The Care Plan dated 03/17/11 documents R5 is at risk for falls and the following approach: " Keep call light within reach at all times. "

The MDS dated 08/14/11 documents R5's cognitive ability as intact (Brief Interview for Mental Status, 14 out of 15). The MDS dated 08/14/11 documents R5 as needing only supervision and set up assistance with eating. On 10/04/11 R5 fed herself lunch without difficulty. On 10/04/11 at 2:00pm R5 demonstrated manual dexterity needed to use the call light by doing needlework indepently in her room.

E2, DON, verified that E7, CNA, and E8, CNA left R5 ' s call light out of reach and were disciplined " for failure to leave call light in resident ' s reach. "

The Job in Jeopardy document confirms E7 left " R5 without her call light in a comfortable position and within easy reach.

(B)