STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146055	A. BUILDING _____ B. WING _____	11/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FINNIE GOOD SHEPHERD N H	400 SOUTH MAINCROSS STREET GALATIA, IL 62935

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F 520	Continued From page 55 how the facility develops and implements plans to remediate quality problems, E9 stated, "They used to develop a plan on a form. I don't know how they're doing it now." E9 added, "QA is the quality of life for residents. Most all the direction just comes through E1."	F 520		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210b) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care 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: 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 requirements were not met as evidenced by: Based on record review, interview and observations, the facility failed to comprehensively assess and analyze all incidents	F9999		

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F9999	Continued From page 56	F9999		

and accidents and failed to provide a safe environment for 7 (R2, R3, R4, R5, R7, R9, R10) of 7 residents reviewed for safety issues from the sample of 11, and 2 residents (R12, R13,) in the supplemental sample. This failure resulted in R3 sustaining a fracture of the right tibia/fibula.

The findings are:

1. R3 is a 90 year old resident with diagnoses that include Dementia, Osteoarthritis, and Osteopenia as noted on the November 2011 physician order sheet and a 5-09-11 x-ray report. The facility incident report for 5-09-11 indicated that R3 was being pushed in a wheeled recliner like chair with the chair in the upright position and as staff attempted to enter a shower room R3 "put her feet down on the floor" then yelled out, complaining of pain to her right ankle. Attached to the Facility Incident Report was additional information which was sent to Illinois Department of Public Health. This 5-09-11 report stated that R3 had put her feet on the floor to resist going into the shower and a "pop" was heard. E7-Licensed Practical Nurse, was interviewed on 11-16-11 at 2:00 PM and verified the above information. An x-ray report dated 5-09-11 indicated that R3 was diagnosed with a fracture to the right tibia/fibula.

R3's 02-11 resident assessment completed prior to the 5-09-11 incident indicated that R3 required extensive to total care with mobility from one area to another as well as with other activities of daily living.

2. R3 was observed on 11-16-11 at 2:00 PM in

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F9999	Continued From page 57	F9999		

bed with a half side rail up on both sides of her bed. The right side rail was noted to have a 4 inch gap from the mattress edge to the side rail and the left side rail had a 2 and 1/2 inch gap. R3's side rail assessment dated 8-20-11 has R3 assessed as having no risk if side rails are used. There is no indication that the facility has considered the the use of these side rails as an environmental risk for R3.

3. R10 was observed on 11-18-11 at 2:00 PM in bed with full side rails up on both sides of the bed. R10's fall risk assessment dated 11-09-11 indicate that R10 is high risk for falls and that side rails are used for safety and mobility. The side rail assessment dated 11-9-11 is marked as "yes" for there being a possibility the resident will climb over the side rails. A nurses note dated 10-13-11 indicated that R10 was "very restless in bed". There is no indication that the facility has considered the the use of these side rails as an environmental risk for R10.

4. On 11-15-11 at 1:30 PM, R7 was assisted onto the toilet by Certified Nurse Aide (CNA) E15 and Licensed Practical Nurse (LPN) E5. Upon transferring R7 back to her wheel chair E5 and E15 failed to use the gait belt during the transfer. Both staff just held R7 in th axilla region as they helped her stand and transfer into her wheel chair.

5. During tour on 11-15-11 at 10:35 AM, LPN E5 was observed transferring R13 onto the toilet. E5 did not use a gait belt with this transfer. R13 stated, "Don't let me fall." as her knee gave slightly during the transfer.

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F9999	Continued From page 58	F9999		

6. On 11-15-11 at 1:05 PM, R12 was observed to be reclined back in a soft chair sleeping. No staff were present in or around R12's room. During tour on 11-15-11, R12 was noted by LPN, E5 to be at risk for seizures and required padded side rails for safety. In the reclined chair R12 had no protection and the device elevated R12 approximately 3 feet off of the floor.

7. According to the facility fall risk assessments completed on 5-13-11, 6-10-11, 08-12-11 and 11-9-11, R5 has high risk for falls. The incident reports for R5 document that she was found on the floor on 06-04-11 with no injury and no interventions to prevent further falls put in place. Another incident report dated 06-05-11 documents that she fell in the dining room and fractured her wrist. There were no new interventions put in place. On 06-09-11, R5 fell in her bathroom and again no new interventions were put in place.

On 11-16-11 at 2:20 pm and 11-17-11 at 1:30 pm, R5 was observed trying to stand up with her pelvic restraint still tied and in place. On 11-17-11, R5 managed to get a drink from the water fountain while still tied to her wheel chair with her pelvic restraint. The assessments for the pelvic restraint do not address this behavior or assess the pelvic restraint as a hazard for R5.

8. A. During the environmental tour of the facility on 11-17-11 at 9:30 am The mattresses were too short of the bed frame in the following areas: room 29- bed 2, room 27- bed 3, room 26- bed 1. According to the room list. There are no residents residing in these rooms.

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F9999	Continued From page 59	F9999		

B. Resident room 29, which is unoccupied has a loose right side rail on bed 2.

C. Resident room 27 - bed 2 has a right side rail that is 3.5 inches out from the bed.

9. E7 was observed while giving an insulin injection on 11-16-11 at 9:00 AM. After giving the injection to R9 while in R9's room, E6 did not have a sharps container available and carried the used syringe back up the hall and disposed of it in the medication room sharps container.

10. According to an incident report dated 10/29/11, R2 was "found in floor on left side" at 3:00 p.m. in R2's room. The report asks whether restraints were in use at the time (yes or no)" and this section was left blank. The report asks, "What was the person doing when incident occurred?" and the answer given is "unknown." A comment on the Side Rail Assessment, dated 10/29/11 stated, "Had fall. Unknown if out of bed or w/c (wheelchair). SR (side rails) up x 2 (1/2)." A corresponding Nurse's Note, dated 10-29-11, stated, "Found on floor in her room." No time was documented on this note.
At 1:45 p.m. on 11/16/11, when asked for an investigation related to R2's accident, E3, Office Manager stated, "There was no investigation because that was witnessed." E3 then pointed to a name on the form, and indicated the named Certified Nurse Aid (CNA), E19, had witnessed the incident. When asked whether a statement had been taken from E19, E3 said no.
11. During the initial tour of the facility on 11/15/11, at 9:30 a.m., E7, Licensed Practical Nurse, stated that R2 was restrained with a vest restraint when she was in her bed, and also when

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F9999	Continued From page 60	F9999		

she was up in her wheeled reclining chair. When asked how the restraint was attached, E7 stated that the the straps of the restraint were attached to the frame of the bed.
According to the facility Face Sheet dated 10/18/11, R2 was admitted to the facility on 10/18/11. According to a side rail assessment dated 10/18/11, R2 "has had frequent falls before adm (admission). She has a fx (fractured) patella. Staff will use sr (side rails) up x 2 (1/2) and a bed alarm for safety. Will monitor." A comment on the Side Rail Assessment, dated 10/29/11 stated, "Had fall. Unknown if out of bed or w/c (wheelchair). SR (side rails) up x 2 (1/2)."
According to the Medication Review Record (document not dated or signed), on 11/8/11 a "vest restraint at all times" was initiated for R2 and "2-1/2 side rails and bed alarm" were initiated on 10/18/11. The Application Instruction Sheet provided with the vest restraint device states, "After applying a restraint or self release product, always put all side rails in UP position. Side rail covers and gap protectors, especially with split side rails, may be required to keep the patient on top of the mattress and avoid entrapment zones." The illustration shows a bed with full side rails in the up position.
R2 was observed restrained in her bed on 11/15/11 at 1:30 p.m. and 8/17 11 at 1:30 p.m. with 1/2 side rails in the up position.
The Risk Assessment dated 11/9/11 also indicated that R2 had a low bed. However, R2's bed was observed during the initial tour on 11/15/11 at 9:30 a.m. and again while R2 was observed in bed (above) and the bed was not visibly lower than other facility beds.
According to the Medication Review Record (document not dated or signed), on 11/8/11 a

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F9999	Continued From page 61 "vest restraint at all times" was initiated for R2. According to the Application Instruction Sheet provided with the vest restraint device, "A patient in a supine position who cannot sit up requires extra vigilance. Should the patient vomit, he/she could aspirate his/her vomitus and suffocate. Monitor constantly and be prepared to intervene at the first sign of danger." R2's care plan dated 10/28/11 failed to discuss monitoring of the restraint device to ensure R2's safety. 12. According to Nurse's Notes dated 4/28/11, R4 fell in his room and sustained a neck injury. According to a Consult Report dated 4/30/11, R4 sustained a C1 Burst Fracture in the accident. The Incident Log representing facility incidents for the preceding 12 months, from November 2010 thru November 2011, which was presented to the survey team as evidence of monitoring all facility incidents, contained no information regarding R4's accident. (B)	F9999		