STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145389	A. BUILDING _____ B. WING _____	C 03/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATSEKA REHAB & HLTH CARE CTR	**715 EAST RAYMOND ROAD WATSEKA, IL 60970**

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F 323	Continued From page 4 3. The Nurse's Notes dated 2/17/12 at 6:00am state, "[R3].....on floor, laying on left side next to w/c....Laceration observed to left cheek and nose.....transfer to ....ER[Emergency Room] for eval [evaluation]." The Quality Care Reporting Form dated 2/17/12 states, "Fell out of w/c. Recommend staff inservice to place [laptop cushion] correctly." E2 stated on 3/21/12 at 10:15am that staff placed the laptop cushion on R3's wheelchair "backwards." E2 stated because of how the laptop cushion is shaped when it is hooked to the arm of the wheelchair backward, there is then room for R3 to "maneuver and [R3] slid under the [laptop cushion]", landing on the floor.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.1210b) 300.1210d)6) 300.1220b)3) 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.	F9999		

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F9999	Continued From page 5 d) Pursuant to subsection (a), 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 300.1220 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 months. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.	F9999		

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F9999	Continued From page 6 These Requirements are NOT MET as evidenced by: Based on interview and record review the facility failed to implement fall prevention interventions for one of three residents (R3) reviewed for falls, in a sample of three. This failure resulted in R3 rolling out of bed, and falling to the floor, resulting in a Frontal Head Laceration and a Subarachnoid Hemorrhage. Findings include: 1. The Physician's Order Sheet (POS) dated 3/1-3/31/12 states that R3 has a diagnosis of Alzheimer's. The Minimum Data Set dated 2/29/12 states that R3 has cognitive problems and requires total assist with transfers, dressing and toilet use. The assessment states that R3 requires extensive assist with eating, bed mobility, is incontinent of bowel and bladder and has a history of falls. The Care Plan dated 12/8/11 identifies the following interventions for R3: "Alarm device to bed and chair (pressure alarm) to alert staff when [R3] is attempting self transfer..." ; "High/Low electric bed to be positioned closer to floor level when [R3's] in it (with mat to floor on Lt[left] side of bed)" and "May have [laptop cushion] device to w/c [wheelchair] when up for safety purposes..." The Nurse's Notes dated 1/5/12 at 3:00am states R3 was found on her hands and knees on the floor on the right side of the bed. E2, Director of Nurses (DON) stated on 3/21/12 at 10:15am that R3's bed position was changed after she rolled	F9999		

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out of bed. E2 stated before the fall, R3's floor mat was on the left side of the bed, but after the fall was moved to the right side. E2 stated R3's bed was moved next to the wall (left side) and the floor mat placed on the right side of R3's bed.

The Nurse's Notes dated 3/3/12 at 4:25pm state, "...[R3] lying on floor next to her bed on her left side. Approx [approximate] 3 1/2 cm[centimeter] gaping laceration on Rt.[right] side of scalp-temporal region....transport to ER...."

The History and Physical dated 3/3/12 states that R3 has a diagnoses of "Subarachnoid hemorrhage secondary to a fall" as well as a "laceration over the frontal head."

E7, CNA, stated on 3/20/12 at 3:35pm that he and E4, CNA, put R3 to bed to change her as she had been incontinent. E7 stated they changed R3 and both left the room, leaving R3 in bed. E7 stated at that time R3 was lying on her side facing the wall, the bed was in low position and the floor mat was in place. E7 stated he came back into the room without E4 and started to get R3 ready to get up. E7 stated he moved the floor mat from the side of the bed, and put it between the dresser and wall. E7 stated he then walked over to the door of the room, looked out, and when he turned around, R3 was on the floor with blood under her head. When asked what position the bed was in, E7 stated, "low position." When asked if he was sure the bed was in low position as the written statements by E6, RN and E8, LPN (Licensed Practical Nurse), both stated the bed was in the regular position, not low, E7 stated, "I thought the bed was in low position, but evidently it was raised, it was up." E7 stated that R3 does

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roll around in bed by herself and thought she had rolled out of bed once before while residing on a different hall.

E6, RN(Registered Nurse) stated on 3/21/12 at 10:30am that she was walking down the hall on 3/3/12 when she heard E7 call for help and was first in the room. E6 stated when she got into R3's room, R3 was lying on the floor with a lot of blood around her head. E6 stated R3's bed was in "an elevated position, normal bed height, but it is supposed to be a low bed." E6 stated staff had raised the bed in preparation for getting R3 up and the floor mat was not on the floor. E6 stated, "It looked like a raised bed and she [R3] rolled out of bed."

E8, LPN, stated on 3/21/12 at 10:00am that E7 came and got her and when she went into R3's room E6 was applying pressure to the laceration on R3's head. E8 stated there was a pool of blood on the floor. E8 stated R3's bed "was not in low position." E8 stated the bed was "about 3 feet off the floor." E8 stated, "[E7] said [R3] rolled out of bed, the other CNA [E4] left and [E7] went to the door to see, [R3] turned [herself] and was on the floor." E8 stated that R3 was able to "roll herself around in bed."

The undated "Conclusion" states, "It is our conclusion that while the CNA [E7] is at fault for removing the floor mat, raising the resident's [R3] bed, and stepping away from the bed, this is not the cause of the resident's fall. The shifting of the air within the mattress is the direct cause of [R3's] fall...."

E2 stated on 3/20/12 at 3:05am R3 was on an air

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mattress at the time of the fall. E2 stated he re-enacted the incident and while he was laying on the air mattress, when he rolled to the side, the air mattress, "held me for a minute, then I felt the mattress push me out of the bed." E2 stated, "Staff [E7] made the mistake of pulling the [floor] mat away, bed was up and [E7] stepped away."

2. The Nurse's Notes dated 1/26/12 at 6:00am state, "[R3] Fell forward out of w/c, struck L[left] forehead, received 4 [inch] bump with blue bruising; 2 superficial tears to bridge of nose....." The Quality Care Reporting Form dated 1/26/12 states, "Fell out of w/c, recommend inservice for staff to ensure [laptop cushion] is in place when [R3] is up in w/c."

E5, CNA(Certified Nurse Aide), stated on 3/21/12 at 11:10am that she heard R3 hit the floor as she came around the corner of the hall. E5 stated the laptop cushion was not on R3 when she found her.

E2 stated on 3/21/12 at 10:15am that the laptop cushion was not put in place when staff got R3 up in the wheelchair that morning(1/26).

3. The Nurse's Notes dated 2/17/12 at 6:00am state, "[R3].....on floor, laying on left side next to w/c....Laceration observed to left cheek and nose.....transfer to ....ER[Emergency Room] for eval [evaluation]." The Quality Care Reporting Form dated 2/17/12 states, "Fell out of w/c. Recommend staff inservice to place [laptop cushion] correctly."

E2 stated on 3/21/12 at 10:15am that staff placed the laptop cushion on R3's wheelchair

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F9999	Continued From page 10 "backwards." E2 stated because of how the laptop cushion is shaped when it is hooked to the arm of the wheelchair backward, there is then room for R3 to "maneuver and [R3] slid under the [laptop cushion]", landing on the floor. (B)	F9999		