STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146058	A. BUILDING _______ B. WING _______	C 03/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVANSTON NURSING & REHAB CTR	**1300 OAK AVENUE** **EVANSTON, IL 60201**

(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 4 R3 was asleep in bed. On 3/29/12 at 4:00PM, E7 asked should it be on the floor. At 4:25PM with E1(Administrator)R3 remained asleep. At this time R3 was positioned on her right side with arms and legs hanging over the side of bed. R3 is 94 year female with history of falls on 12/19/11 and 1/15/12 (hospitalization due to injury). R3 has diagnoses to include; Senile Dementia, Congestive Heart Failure.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATION: 300.1210d)6) 300.1220b)3) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care 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:	F9999		

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F9999	Continued From page 5 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. These regulations are not met as evidenced by the following: Based on observations, interviews and record reviews, the facility failed to analyze the circumstances of falls, re-evaluate for effectiveness of intervention, implement interventions and supervise resident to minimize the risks for recurring falls and serious injuries for two residents (R1,R3) from a sample of four residents reviewed for high fall risk. This failure resulted in R1 being sent to the hospital due to sustaining a head laceration after a fall incident. Findings include: 1). On 3/29/12 at 1:40PM, E4(LPN) stated that she was on the second floor the morning of	F9999		

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F9999	Continued From page 6 1/17/12 at approximately 5:25AM when E5(CNA) came to get her because a resident had fallen in her room on the first floor. E4 stated that she found R1 on the floor, responsive but R1 was lying in lots of blood from right side of R1's forehead. E4 stated she grabbed a towel and applied pressure to R1's forehead to stop the bleeding. E4 stated she assessed R1, as she was alert, asking for help and complaining of pain. E4 stated that another staff member called 911 and the attending physician. E4 stated that she and CNA placed resident in bed and provided support until ambulance came. E4 stated that R1 could sit up in bed and would sit at side of bed but could not walk and had never walked. E4 stated that there was no mat at resident bedside that morning. On 3/29/12 at 1:55PM, E5(CNA) stated on the morning of 1/17/12 she was making her 4th round when she heard a loud boom. E5 stated she went to R1's room and saw her lying on the floor. E5 stated she called out to R1 and R1 answered, "Pick me Up" E5 stated resident had a bump on her head and was bleeding. E5 stated R1 could not walk but could sit up in bed or turn in bed if you ask her. E5 stated resident would ask for extra blankets at night and for her night hat to be placed on her head. E5 stated that R1's bed was in the low position. On 3/29/12 at 2:10PM, E2(DON) stated that she was notified at about 6:00AM the morning of the incident. E2 stated that she was informed by E4 that R1 had fallen out of bed, hit her head and was sent to the hospital. E2 stated she was told that there was a lot of blood on the floor and that E4 stated to her that the ambulance driver was	F9999		

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F9999	Continued From page 7 yelling at her and she did not know why. E2 stated that she was not aware that R1's niece had requested a mat be placed at R1's bedside. E2 stated that a fall mat was placed at the bedside after this fall incident when resident returned back from hospital. E2 stated that R1 was a High Fall Risk for arising from wheelchair but not for bed. On 3/29/12 at 3:15PM, E6(MDS Coordinator) stated that a floor mat should have been in place at resident bedside according to residents fall care plan dated 9/13/2011 due to resident's history of falls and being observed on floor. We don't know what happened and I was not here. E6 stated we educate restorative and CNA's about these things. On 3/29/12 at 3:30PM, E2 stated that the MDS coordinator knows about the mat because she puts in the care plan and should tell staff to provide it. Review of incident report dated 1/17/12 indicates resident sustained a fall at 5:25AM, and was sent to emergency room for head trauma with bleeding from rightside of head. Report indicates that R1 is confused at times, unaware of safety issues, has poor vision and no gait balance,uses wheelchair. Review of Physician's Order Sheet(POS) dated 12/28/11 through 1/14/12 indicates R1 is a 72 year old female with history to include; Altered Mental status,Dementia with psychotic features, Cardiopulmonary Disease, Hypertension, Urinary Tract Infections, Pacemaker and state IV Renal Disease. According to physician's notes dated 1/18/12, R1 admitted on 1/17/12 after a fall at the nursing home, assessment results indicate	F9999		

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F9999	Continued From page 8 abrasion to left knee, right eye/orbit swelling, no skull fractures, small amounts of fluid in left and right maxillary sinuse, sutures placed to right eye and patient confused. Review of consultant caridologist notes dated 8/29/11 indicates R1 at risk for falls due to cardiac ischemia. Psyhiatric evaluation dated 2/22/11 indicates R1 with poor to limited insight, judgement and easily becomes distracted and confused. Several attempts to call different doctors, none were available to being off or out of town. Review or resident fall care risk assessment dated 6/16/11 indicated resident fall risk score was an 8 and on 7/19/11 assessment score was 18, and on 8/17/11 indicate resident assessment score was 16(at risk for falls-no score), 8/30/11 assessment socre (not at risk for falls- no score) on 9/14/11(not at risk for falls), 10/15/11 and 11/02/11(at risk for falls- no scores). On 11/07/11 falls assessment indicates score(16) resident at risk for falls due to intermittent confusion, no able to maintain any gait/balance and is chair bound. On 11/26/1 fall assessment indicates R1 is oriented times to name, place and time, fall score(7) and resident has history of falls within past 3 months, change in gait pattern when walking, jerking or unstable when making turns and resident taking 3-4 medications. On 12/02/11 fall assessment indicates R1 at risk for fall(no score). Lastly, On 1/17/12 fall risk assessment indicates that R1 is dioriented x3 all of the time, chairbound, vision poor score(16). Review of fall risk assessments are inconsistant and implementation of intervention in care plan(mat placement) was not implemented.	F9999		

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F9999	Continued From page 9 B	F9999		