STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145248	A. BUILDING _____ B. WING _____	C 03/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORTON VILLA CARE CENTER	**190 EAST QUEENWOOD ROAD MORTON, IL 61550**

(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 12 On 3-27-12 at 10:30 am, E5 (Social Service) stated on 2-3-12 she heard an alarm sounding and went to R3's room finding R3 on the floor next to her bed. E5 stated R3's side rail was up on the side of the bed where R3 had fallen. E5 said "it looks like (R3) climbed over the side rail." E5 indicated R3's bed had either 3/4 or full side rails at that time. On 3-27-12 at 11:35 am, E4 (Housekeeping Supervisor) stated the following: When R3 returned from a hospital stay on 2-1-12, R3 was moved to another room due to being in isolation. E4 did not move R3's bed to the new room but used the bed already in the room. The new bed in the new room had full side rails on the bed. E4 thought the long rails would be better and R3 would be safer with the full rails. On 3-27-12 at 11:15 am, E16 (Maintenance Supervisor) stated R3 had 3/4 side rails on the bed in the room used before 2-2-12 and full side rails were on the bed R3 was in when she fell on 2-3-12. On 3-27-12 at 11:00 am, E2 stated she was working on 2-3-12 when R3 sustained a fall resulting in a left femur and wrist fracture. E2 stated R3 went over the side rail and landed on the floor. E2 stated both of R3's side rails were up at that time. E2 confirmed R3 had full side rails on her bed instead of half rails, climbed over the rails falling and sustaining a left femur and wrist fracture.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.1210b)	F9999		

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F9999	Continued From page 13 300.1210d)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. 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,	F9999		

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F9999	Continued From page 14	F9999		

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 Requirements are NOT MET as evidenced by:

Based on interview and record review, the facility failed to ensure one of six residents (R3) reviewed with falls in a sample of six had the correct side rails on their bed per their plan of care. This failure resulted in R3 climbing over full side rails and fell sustaining a left femur and wrist fracture.

Findings include:

R3's nursing notes dated 2-3-12 at 3:15 pm state "Summoned to res (resident) room resident lying on the floor next to bed on her Lt. (left) side moderate amt (amount) of blood on floor. Res had been incontinent of BM (bowel movement) tried to climb out of bed towards bathroom and fell. Large hematoma Lt. side forehead and wrist injury complains of right shoulder pain and left hip pain which was noted to be swollen..." Nursing note dated 2-3-12 at 6:00 pm states R3 was

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F9999	Continued From page 15	F9999		

admitted to the hospital with a fracture to the left femur and left wrist. Facility's Accident/Incident Investigation dated 2-3-12 states "Resident was noted on the floor next to bed. BM in bed, alarm going off...Resident climbed out of bed and fell onto floor. Hematoma left side forehead left wrist injury left swollen hip."

R3's POS (Physician's Order Sheet) dated 1-16-12 states "may have 1/2 siderails x's 2 to aid with turning and positioning." R3's side rail assessment form dated 5-28-11 and last updated 1-16-12 states R3 is to have two half rails. At the top of this form is this statement "The use of bed rails as a restraint is prohibited unless they are necessary to treat a resident's medical symptom. If the bed rails are used for resident safety it is not considered a restraint." Items checked on R3's assessment were "alteration in safety awareness due to cognitive decline and history of falls." There is no documentation of how R3's side rails were being used to treat a medical condition or enabling R3.

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F9999	Continued From page 16	F9999		

used the bed already in the room. The new bed in the new room had full side rails on the bed. E4 thought the long rails would be better and R3 would be safer with the full rails.

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