STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145985	A. BUILDING _____ B. WING _____	03/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY NURSING & REHABILITATION	UNIVERSITY DRIVE EDWARDSVILLE, IL 62025

(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 441	Continued From page 12 1. R1's Minimum Data Set (MDS), dated 1-17-02, documented cognitive impairment, incontinent of bowel and bladder, extensive assistance of two plus persons physical assistance with mobility, total dependence of two plus persons physical assistance with transfer and toileting. R1's chart documented R1 had a history of indwelling catheter usage in 2011. During observation of R1's incontinent care, on 3-20-12 at 11:35a.m., E15, Licensed Practical Nurse (LPN) and E14 Certified Nurse Aid (CNA), did not completely cleanse R1's penis or penial area. R1 was observed urine soaked with a medium amount of soft formed fecal matter. E16 did not change her gloves or provide handwashing after she cleansed R1's fecal matter and then touching R1's skin and clean linens. 2. On 3/21/2012 at 1:20 PM, CNA's E12 and E13 were doing incontinent care on R5. Both walked R5 to the bathroom from the doorway and put R5 in the toilet. E12 and E13 were observed washing their hands and donning gloves. E13 took off the adult incontinent brief which was minimally wet with urine and had a small amount of dark brown fecal material, fastened a new pair of adult briefs between R5's legs, then cleaned R5 with several washcloths from front to back and wiped her dry. E13 did not take off gloves and do any hand hygiene prior to putting on the clean adult briefs and pulling up R5's pants.	F 441		
F9999	. FINAL OBSERVATIONS	F9999		

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F9999	Continued From page 13 LICENSURE VIOLATIONS 300.1210b) 300.1210d)6) 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: 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 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)	F9999		

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F9999	Continued From page 14 THESE REQUIREMENTS HAVE NOT BEEN MET AS EVIDENCED BY: Based on interviews, observations and record review, the facility failed to implement safety measures including adequate supervision and assistance to prevent falls for 2 residents of 9 residents (R1 and R12) reviewed for falls in a sample of 21.. Findings include: 1. The Admission Sheet documents that R12 was admitted to the facility on 9/22/11 following hospitalization for a fractured femur from a fall 9/19/11 at another nursing home. According to the Incident/Accident Log, R12 has had repeated falls documented on 9/26/11, 10/1/11, 10/26/11, 12/10/11 and 12/13. The Minimum Data Set (MDS) dated 9/29/11 identifies that R12 required extensive assist of one staff for bed mobility and transfer. According to the Incident/Accident Log, R12 fell on 9/26/11. The Interdisciplinary Notes (IDT) dated 9/26/11 indicates she "leaped from bed, across room" as the nurse was outside of her room. Alarm was sounding. A low bed was implemented. There is no explanation as to why the facility would implement a low bed when she was doing a self transfer without assistance and fell across the room from the bed. The report documents that R12 fell again on 10/1/11 at 10:30am and was found on the floor. The fall was unwitnessed. The IDT notes indicate she was a low bed at the time and had a mat floor alarm but was "constantly on the move." On 10/26/11 at 4:05pm, R12 was sitting in a chair at the nurses station and stood at side with	F9999		

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hand on the foot rest when she rolled herself toward the foot rest and slid to the floor. The alarm sounded but staff was unable to reach her before she fell to the floor.

On 12/10/11 at 7:40am, the IDT notes indicate R12's alarm sounded and when staff responded found R12 had pulled herself up attempting to stand to ambulate causing herself to fall to the floor. She obtained as reddened area to her head. The IDT notes indicate R12 had a seat belt on which she removed herself prior to standing up.

On 12/13/11 at 10:20pm, R12's alarm sounded again according to the IDT notes when she removed her belt prior to standing up and fell to the floor. Again, there is no indication as to why the staff were unable to respond more timely to the alarm and no indication further assessment was done toward a more appropriate device since she removed the belt and staff were unable to respond to the alarm to prevent falls. There are no assessments/documentation available to explain why R12's safety device were chosen.

The MDS dated 12/8/11 indicated that R12 had cognitive impairment and still required extensive assist of one staff for bed mobility, transfers and locomotion outside of the room. The MDS also identified that R12 had balance deficits with on/off toilet being "unsteady" requiring human assistance. The care plan reflects R12's high risk for falls and includes interventions for alarms, bedside mat alarm, side rails among others but fails reflect her frequent prior falls and the need for constant supervision and quick response to the alarms sounding. R12 has also been placed on Hospice (November 2011).

According to an Incident/Accident Report, on 1/25/12 at 5:30am, R12 was on the toilet and

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"leaned over et (and) fell to floor L (left) side" receiving a 3 cm (centimeter) skin tear to her left upper extremity and a 2 inch laceration to the left side of her head. R12 was sent to the emergency room for treatment of staples for the head laceration.

The Nurse Investigation of Accident/Incident dated 1/25/12 documents that R12 fell from the toilet, was seen 2 minutes prior to the fall and that her body alarm was not sounding. The investigation found that the Certified Nurses Aide (CNA) transferred R12 to the toilet and heard another residents alarm sounding across the hall. The CNA left R12 unattended on the toilet to go answer the other alarm. When she returned, R12 was laying on the floor. The investigation indicates the staff member was re- inserviced on leaving residents unsupervised. This information was confirmed by E2, Director of Nurses on 3/22/12 at 10:30am when she acknowledged that R12 should not have been left unattended by staff to respond to another residents alarm sounding stating she had no additional information to provide. E2 also stated R12 who had an chair alarm would not have had it on while on the toilet.

2. R1's MDS, dated 1-17-02, documented cognitive impairment, extensive assistance of two plus persons physical assistance with mobility, total dependence of two plus persons physical assistance with transfer and bathing.

R1's Incident/Accident Report, dated 1-3-12,documented R1 incurred a laceration to his left upper eye brow, 1.5cm length, as a result of E18, Certified Nursing Assistant (CNA), placing R1 in the wrong shower chair during R1's shower. R1 was sent to a local hospital after

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F9999	Continued From page 17 falling from the shower chair. (B)	F9999		