STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145585	A. BUILDING ______ B. WING ______	04/27/2012

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CASEYVILLE NURSING & REHAB CTR	601 WEST LINCOLN AVENUE CASEYVILLE, IL 62232

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F 520 — F 520

Continued From page 111

weekly department supervisor meetings, the monthly all staff meetings, or the quarterly quality assurance meetings. E2 confirmed there is no attendance documented at these meetings. E2 stated, "No official records are kept. We just know our jobs and do it. No one takes any notes."

3. The Resident Census and Conditions of Residents, CMS 672, dated 4/12/12 documents that the facility has 117 residents living in the facility.

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F9999 — F9999

FINAL OBSERVATIONS

LICENSURE FINDINGS:

300.610a)
300.1210b)
300.3240a)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder.

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F9999	Continued From page 112 These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. 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. 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) These requirements were not met as evidenced by: Based on observation, interview and record review, the facility failed to adequately assess/monitor, and provide services to address pain for two of nine residents (R7 and R11) reviewed for pain management in the sample of 24. This failure resulted in R11 being in pain and having decreased participation in therapy. Findings include:	F9999		

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1. R11's Physician's Order Sheet, POS, dated April 2012, documented she had partial diagnoses of Hernia Repair on 3/6/12 and Fibromyalgia.

R11's Nurse's Note dated 2/8/12 at 9:15 PM documented "c/o (complain of) back pain. PRN (As Needed) given s (without) some sign of relief. (Z1, R11's physician) office notified. State will see this Fri- cont (continue) PRN until then. "

R11's Nurse's Note dated 2/9/12 documented "complaining of severe abdominal pain and lower back pain." R11 was sent to the Emergency Room.

R11's Nurse's Note dated 2/10/12 at 1:10 PM documented "Seen by (Z10, Z1's Physicians Assistant, PA) c (with) new orders received for x-ray, L/S (Lumbar/Sacral) spine, pelvis, bilateral hips due to pain et (and) residents request. Refer to pain specialist. Psych consult-chronic Pain. Increase Neurontin to 300 milligrams po (by mouth) TID (three times daily)." There was no documentation in R11's medical record documenting the facility had contacted a pain specialist.

R11's Physician's Order dated 2/24/12 documented "d/c (discontinue) flexeril, XR's WNL (X rays Within Normal Limits), meds makes pt (patient) lethargic, concern w/ (with) somatic complaints. psych to see pt. assure pain specialist." Again, there was no documentation in R11's medical record documenting the facility had contacted a pain specialist, 14 days after the initial order.

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Continued From page 114

R11's Nurse's Note dated 3/1/12 at 11:00 AM documented "Res (Resident) c/o (complain of) severe backpain this shift. Res is refusing to get (up) for meals or to participate in therapy. PRN (As Needed) meds admin (administered) but res voices 0 relief. Res is requesting the flexeril & ibuprofen previously prescribed. (Z1, R11's physician) notified of c/o pain and res. request. Awaiting response." There was no referral to the pain specialist documented.

R11's Nurse's Note dated 3/6/12 documented she was transported to the hospital for surgery. R11 received a Hernia Repair. R11 was readmitted to the facility on 3/10/12. Her Physician's Order dated 3/10/12 documented she should receive Hydrocodone (a pain medication), 500/5 milligrams, 1-2 tablets, every four to six hours as needed.

On 4/10/12, at 3:40 PM, an interview was conducted with R11. She stated she had a long history with pain and pain medications. She stated she had a history of Fibromyalgia , a fractured ankle which didn't heal right, and a spinal column fusion. R11 stated recently in March 2012, she had a hernia repair which also contributes to her pain. R11 stated in December 2011, she was admitted to the hospital for using too many pain medications. R11 stated she saw a pain specialist while in the hospital and was able to discontinue the use of many of her pain medications. R11 stated that usually her pain level is at a level 7 on the pain scale (pain scale- 0 no pain to 10 the worst pain experienced). R11 stated she has an order for one to two tablets of Hydrocodone every four to six hours as needed.

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F9999	Continued From page 115 R11 stated she usually request one tablet not two because she doesn't like the way the nurse's look at her. R11 stated the nurse's are aware of her history and she (R11) feels they think she is an addict. R11 stated the last few days she hasn't been able to attend therapy because of lower abdominal and side pain. On 4/12/12, at 9:32 AM, an interview was conducted with E71, Physical Therapy Assistant (PTA) regarding R11's therapy. E71 stated R11 is in a lot pain related to a hernia and other issues. E71 stated she attempted to contact Z1 regarding R11's pain, but because of R11's history of being a drug seeker she did not prescribe anymore medication. When asked if R11's pain affects R11's therapy, E71 responded "Yes. You can see it in the way she moves. On days when she is in extreme pain her balance is effected. She has pain in one of her feet and abdominal pain. She usually doesn't skip therapy but it does effect it." On 4/12/12, at 1:52 PM, an interview was conducted with E2, Director of Nursing, DON. E2 stated R11 had an appointment for an orthopedic consult regarding her ankle. E2 stated she was not sure if R11 ever saw a pain management specialist. E2 stated "She refuses a lot." There is no documentation in R11's chart that the appointment with a pain management specialist was obtained, 32 days after the initial order for referral. On 4/12/12, at 3:55 PM, an interview was conducted with R11. R11 stated Z10 had discussed her seeing a pain management specialist. R11 stated nothing had ever been done about it. R11 stated she had seen a pain	F9999		

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F9999	Continued From page 116	F9999		

management specialist in the past and felt this would help her. R11 stated "I know what happened in the past but I know I have pain. Maybe a pain specialist could help with other things other than medications." When asked if she had ever refused to go to a pain specialist she stated "No, I would go."

2. The History and Physical, dated 2/24/12, documents, in part, R7 "has a deep thigh wound, deep, about more than 5 cm (centimeter) noted, and some oozing but no purulent drainage." The Care Plan, dated 3/23/12, documents that R7 has a healing abscess to the left medial thigh, measuring 13.5 cm X 4.0 cm X 1.0 cm. The POS for April 2012 documents an analgesic medication order of "Hydrocodone/Acetaminophen 5/235 mg (milligram), take 1/2 tablet by mouth every 6 hours as needed for pain."

On 4/11/12, at 10:00 AM, E5, Registered Nurse (RN) assisted R7 to abduct her left thigh to gain access to her wound. R7 stated, "You're hurting me." E4, Licensed Practical Nurse (LPN) cleaned R7's wound with a wound cleanser, then began to pack with open areas of the wound. R7 again cried out in pain. E4 and E5 did not ask R7 to identify the severity of her pain. On 4/11/12, at 10:20 AM, E4 had completed the treatment and had dressed R7's left inner thigh.

The Medication Administration Record (MAR) for April 2012 documents R7 only received 2, 325 mg Acetaminophen tablets at 10:45 AM, after the treatment to her left inner thigh. The Medication Notes section of the April MAR completed by E4, documents no site for the pain and no pain scale

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assessment as to the severity of R7's pain. The pain assessment section of the MAR documents R7 as having no pain during April 2012.

The Care Plan for R7, dated 3/23/12, documents, in part, an intervention as "Monitor for and ask her to report any pain, document and treat all reported or observed pain." After R7's treatment on 4/11/12, a new POS was obtained, "Vicodin 5/325 mg, one by mouth one hour prior to treatment."

The facility's policy and procedure, entitled 'Wound Care Protocols' documents, in part, "If resident expresses pain, administer ordered analgesics or as soon as practicable obtain orders for analgesics from the physician."

The facility's policy and procedure, entitled 'Pain Management' documents, in part, "It is the right of the resident to expect from the staff a commitment of on-going pain management. Pain and its intensity will be assessed upon admission, at least every 8 hours and at discharge using a scale appropriate to the resident's level of understanding."

(NO VIOLATION)

LICENSURE VIOLATIONS:

300.610a)
300.696
300.1210b)
300.3240a)

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F9999	Continued From page 118 Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.696 Infection Control a) Policies and procedures for investigating, controlling, and preventing infections in the facility shall be established and followed. The policies and procedures shall be consistent with and include the requirements of the Control of Communicable Diseases Code (77 Ill. Adm. Code 690) and Control of Sexually Transmissible Diseases Code (77 Ill. Adm. Code 693). Activities shall be monitored to ensure that these policies and procedures are followed. 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	F9999		

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F9999	Continued From page 119	F9999		

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.

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)

These requirements were not met as evidenced by:

A. Based on observation, interview and record review, the facility failed to follow isolation precautions / protocols, when caring for residents with infections, failed to clean and disinfect medical equipment, and failed to implement ongoing surveillance of employee isolation practices, for residents with Methicillin Staphylococcus Aureus (MRSA) and Clostridium Difficile (C-diff). This has the potential to affect all 117 residents in the facility.

Findings include:

1. On 4/13/12 at 9:05 AM, E4, Licensed Practical Nurse, (LPN) prepared to give medications to R16 per Gastrostomy Tube (G-Tube). E4 stated that R16 took his medications via Tube (G-tube). Two signs were observed hanging on the door to R16's room and they documented; Droplet Precautions, and Contact Isolation. E4 put on gloves and a mask and brought the medications into R16's room and set them on top of the night stand. In the room a stethoscope and blood pressure cuff were observed sitting on top of a

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F9999	Continued From page 120 cabinet across from R16's bed. E4 then took her personal stethoscope from around her neck and used it to auscultate R16's G-tube site. When finished E4 placed the stethoscope back around her neck/shoulders. Once finished giving the medications, E4 removed her gloves and mask, washed her hands and left the room. E4 failed to clean the stethoscope around her neck, and after pushing the medication cart up the hall towards the nurses station, E4 began putting her supplies away in the cart drawers. On 4/13/12 at 9:33 AM, E2, Director of Nurses came to the medication care where E4 was working. E2 stated "The facility policy is that staff are to use the stethoscope that has been placed in the room of all residents with C-Diff. Staff are not to use personal stethoscopes on residents placed on contact isolation. E4, agreed with E2 that this was the facility policy. E4 then gasped and said, "Oh, I used my stethoscope on R16." When asked what is the policy for cleaning medical equipment E4 stated "it should be cleaned with a bleach wipe." E4 showed where the container with the bleach wipes was stored on the cart. E4 then continued putting her supplies away. At 9:35 AM, E4 was asked if she had cleaned her stethoscope since leaving R16's room. E4 stated, "Oh, No, I forgot to do it. Do you want me to clean it now?" E4 then cleaned her stethoscope. On 4/17/12, at 8:50 AM, E10 identified the following residents currently have infections; R15 and R16 have active C-Diff, and R10, R7, R16, R83 have MRSA infections. E10 stated "I do infection control inservices with staff, quaterly throughout the year. Staff train on	F9999		

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all aspects of infection control including contact isolation. Inservices are mandatory for nursing / cna staff and they include a written test when completed. Housekeeping also is trained on how to clean rooms of residents with C-Diff. At this time we have no program for monitoring staff once they complete the inservices. The nurses should know what to do, they are taught this in nursing school." Per the facility policy, residents on contact isolation are to have their own stethoscope and blood pressure cuff in their room as well as thermometer, and glucometer if necessary. Nurses are told "not" to use their own personal stethoscopes on infected patients, and not to bring them into an isolated residents' room." If there is a concern, or I see some one do something wrong when I am on the floor, I will discuss it with the staff member involved. I do not follow staff and check on how they practice infection control unless I am told there might be a problem. No one has told me, and I have not seen, any nurses bringing their personal stethoscopes into the rooms of residents on contact isolation. No one has told me that staff are not using masks when going into the rooms of residents on droplet precautions for MRSA of the Nares.

On 4/17/12 at 9:20 AM, E2 Director of Nursing stated, "Currently there is no program for monitoring staff once they have had attended the inservice on infection control policies. If I am out on the hall and see a staff do something wrong, I will retrain the staff at that time or have E10 do it. There is a nurses meeting once a month, if they tell me there is a concern with infections, I address it at that time. No one has told me that the nurses are taking stethoscopes into the

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F9999	Continued From page 122 resident's rooms with contact isolation. I rely on E10 to be aware of any infection issues, as I am not always able to be out on the floor with the residents due to all the paperwork I do." 2. During tour of the facility on 4/10/12, at 9:20 AM, E16, Registered Nurse (RN) reported R7 was on droplet precaution isolation for MRSA (Methicillin resistant staphylococcus aureus) of the nares. A yellow isolation sign was posted on R7's door. During the medication pass on 4/10/12, at 12:14 PM, E16 entered R7's room wearing gloves. E16 did not apply a mask to her face. R7 was not wearing a protective mask. E16 leaned over R7 and lanced her right forefinger to check her blood sugar. After removing her gloves and washing her hands, E16 left R7's room and prepared medication for R8. 3. On 4/10/12, at 4:20 PM, E16 entered the room of R6 to check her gastrostomy tube for placement with use of her personal stethoscope that was hanging around her neck. After completing the medication pass and water flush for R6, E16 removed her gloves and entered R15's room to wash her hands. E16 did not gown or glove prior to entry to R15's room . An orange sign for contact isolation was posted on R15's door. E16 used her personal stethoscope to auscultate R15's chest. E16 failed to use the dedicated stethoscope located in R15's room, due to his diagnosis of C-diff. In an interview on 4/12/12, E16 stated, "I remember listening to his (R15) lungs using my own stethoscope, and I cleaned it with alcohol	F9999		

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pads." E16 confirmed there was a stethoscope in R15's room she should have used. E16 reported R15 has had no diarrhea or loose stools since she began taking care of him since 4/07/12. E16 reported R15 began to display shortness of breath on 4/10/12.

In an interview on 4/11/12, at 3:00 PM, E10, Infection Control Nurse reported R15 had been treated at the hospital for C-diff prior to his admission to the facility on 3/28/12. E19 reported R15 had not been tested for C-diff since admission, although the physician had ordered stool cultures on 4/02/12. E10 reported she thought the culture was ordered because R15 started having loose stools. No documentation of R15 having loose stools or diarrhea could be found in R15's Nurses Notes or the bowel movement record listed on the Medication Administration Record (MAR) for April 2012.

4. On 4/16/12, at 12:23 PM, a visitor came out of R7's room with her mask on. R7 remained on droplet isolation. The visitor walked toward the nurses station and did not cleanse her hands. The visitor quickly returned with the mask hanging from her ear, threw it away and reapplied a new mask. E58, Certified Nurses Aide, (CNA) was in R7's room with gloves and a mask on, cleansing R7's chair with bleach wipes. E8 looked at R7's visitor and stated, "She (the visitor) always does that." On 4/16/12, at 12:30 PM, E58 left R7's room after removing her gloves and mask, but did not wash or cleanse her hands.

In an interview on 4/17/12, at 9:15 AM, E7, CNA reported she had been inserviced by the Infection

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F9999	Continued From page 124 Control Coordinator, E10. However, the facility has not asked for a return demonstration to demonstrate competency related to infection control and isolation procedures. E7 reported she has been employed at the facility for 2 years. E7 reported alcohol swabs are used to clean stethoscopes. E7 reported she does not know what product is used to clean a resident's room who is infected with C-diff. E7 stated, "It's in a small spray bottle." In an interview on 4/18/12, at 11:55 AM, E8, CNA reported the facility had never asked her to perform a return demonstration related to infection control and isolation procedures until the morning of 4/18/12. The facility's policy and procedure, entitled, 'Respiratory/Cough Etiquette' documents, in part, "6. Droplet Precautions, a. Advise healthcare personnel to observe droplet Precautions (wearing a surgical or procedure mask for close contact), in addition to standard precautions when examining a patient with symptoms of a respiratory infection, particularly if fever is present." The facility's policy and procedure entitled, 'Isolation Precautions' documents, in part, "Isolation precautions will be instituted as an infection control measure to decrease the risk of transmission of virulent and/or clinically significant organisms to residents, staff, and /or visitors. Adhere to proper isolation and standard precautions when caring for the resident. The infection control coordinator will; e. verify that the isolation techniques are implemented in accordance with facility policy. f. Make periodic	F9999		

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rounds to verify staff are adhering to established infection control practices and to monitor the ongoing implementation of isolation techniques.

5. On 4/11/12 at 12:15 PM, E26, Licensed Practical Nurse (LPN), entered R10's room. R10 had an isolation sign on her door and E26 advised surveyor to wear a mask because R10 was on "Droplet Precautions". E26 carried R10's cardboard box with Albuterol solution into the room. E26 set the box directly on R10's overbed table. E26 mixed the nebulizer solution into the nebulizer and turned on the nebulizer for R10, and replaced the box back onto the overbed table. After the treatment was completed, E26 removed her gloves, touched the box of Albuterol, and carried the box over to the sink, setting the box onto a dresser near the sink. E26 washed her hands, picked up the box, left the room, and returned the box of Albuterol into the bottom drawer of the medication cart.

The facility's Isolation Precautions dated 8/24/09 documented (in part), "Make periodic rounds to verify staff are adhering to established infection control practices and to monitor the ongoing implementation of isolation techniques......Supply.... equipment required for regular nursing care inside the room.....Disinfect and or/clean and remove...equipment upon discontuance of isolation precautions.".

On 4/17/12 at 11:53 AM, E2, DON, stated that equipment and medication should not be carried into and out of the isolation room without cleaning/disinfecting.

6. On 4/17/12 at 8:30 AM, E43, CNA, stated

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she had received in-service training in Infection Control approximately one month ago. She stated the Infection Control information covered Isolation policies and procedures. When asked about a resident in isolation that had used a bedpan or emesis basin, E43 stated after the equipment was used, she would place the bedpan or emesis basin into a plastic bag and carry it to the soiled utility room to clean.

E43 demonstrated the procedure by walking with the surveyor to the soiled utility room across from the Nurse's Station, between the 200 and 300 Halls. E43 explained that the bedpan or emesis basin should be sprayed with disinfectant, but could not state the name or type of disinfectant. There was no disinfectant available in the soiled utility room, on the counter or in drawers and cabinets.. E43 stated if there was no disinfectant available, the staff was to request the disinfectant from the housekeeper. E43 stated the equipment was to be sprayed with disinfectant and placed into the sink of the soiled utility room. E43 stated a different shift was responsible for removing the soiled equipment from the sink.

7. On 4/17/12 at 8:45 AM, E42, Housekeeper, was asked by E43 to provide the disinfectant for cleaning the soiled equipment. E42 stated she would ask E21, Housekeeping Supervisor, but E42 stated she would use bleach water or cleanser with bleach. E42 poured bleach into a cup with a black line at the 4 ounce level. R42 poured the bleach into a 32 ounce spray bottle, added water to the 10 ounce mark on the spray bottle, and stated, "That's a 10% solution of bleach water." The bleach solution was incorrectly measured, was a 40% solution.

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8. On 4/17/12 at 8:40 AM, E35, CNA Coordinator, stated he had training in Isolation less than 6 months ago. E35 was asked if a resident on isolation had diarrhea what was the procedure for disposal and cleaning of the bedpan? E35 stated he would dump the contents into the toilet, rinse it out, and bring the bedpain into the soiled utility room for cleaning.

The facility's Isolation Policy documented (in part) that equipment required for regular nursing care should be kept inside the room....Disinfect and/or clean and remove isolation equipment upon discontinuance of isolation precautions.

9. On 4/10/12 at 9:55 AM, during the initial 300 hall tour, E19, Certified Nurse's Aide (CNA), and E20, CNA, were observed entering R10's room which had a sign posted on the door "Droplet Precautions." E19 and E20 walked into the room without donning a mask. E10, Infection Control Nurse, redirected E19 and E20. E10 stated, they should have masked before entering R10's room. On 4/10/12 at 9:55 AM, E10 stated, R10 was on droplet precautions for MRSA (methicillin resistant staphylococcus aureus) in the nares.

10. The Resident Census and Conditions of Residents, CMS 672, dated 4/11/12 documents that the facility has 117 residents living in the facility.

B. Based on observation, interview and record review the facility failed to provide adequate hand washing during incontinent care to prevent the

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spread of infection for 1 of 15 residents (R10) reviewed for incontinent care in the sample of 24.

1. On 4/11/12 at 9:40 AM, E18, CNA, and E19, CNA, were observed providing peri care for R10. R10 had been incontinent of bowel and bladder. E18 had on gloves and cleansed R10's vaginal area. E18 did not change gloves prior to placing her hands on R10's left side and thigh area to roll R10 to her side. E18 cleansed R10's rectal area. E18 removed the soiled gloves, but did sanitize or wash her hands. E18 left R10's room to get more supplies. When E18 returned, she sanitized her hands and put on gloves. E18 cleansed R10's buttocks area. E18 did not change gloves prior to placing her hands on R10's side and thigh to roll R10 to her left side.

The facility's Hand Hygiene/Hand Washing Policy, effective 9/1/09, documents (in part):

2. Employees must wash their hand for 10-15 seconds using soap and water under the following conditions;
b. After contact with blood, body fluids, secretions, mucous membranes, or non-intact skin;
c. After handling items potentially contaminated with blood, body fluids, or secretions"
3. If hands are not visibly soiled then the use of an alcohol based hand rub/gel containing 60-95%ethanol or isopropanol for all the following situations;"
f. Before moving from a contaminated body site to a clean body site during resident care.
j. after removing gloves

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4. The use of gloves does not replace handwashing/hand hygiene."

On 4/20/12 at 8:15 AM, E1 Administrator, stated she would expect the CNA to change gloves and sanitize hands after care of a soiled area before touching a clean area.

(A)

300.610a)
300.1210b)
300.1210d)6)
300.3240a)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary care

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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 300.3240 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)

These requirements were not met as evidenced by:

A. Based on observation, record review and interview, the facility failed to thoroughly identify, evaluate, implement and monitor the use of siderails for two of eleven residents (R7, R13) reviewed for siderail entrapment in the sample of 24.

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F9999	Continued From page 131 Findings include: 1. The Minimum Data Set, (MDS) dated 2/24/12, documents R7 is moderately impaired with cognition, long and short term memory impairment, no impairment to upper extremities and bilateral lower extremity impairment. The MDS documents R7 requires extensive assistance with transfers and bed mobility, with an unsteady balance while standing. The Care Area Assessment (CAA) dated 3/06/12, documents R7 has a history of impaired safety awareness that has resulted in a previous fall from her wheelchair on 1/15/12. The Physician's Order Sheet, (POS), for April 2012 documents R7 has diagnoses, in part, of Alzheimer's Dementia and Cerebral Vascular Accident with Left Side Hemiparesis. The Fall Risk Assessment dated 3/07/12, documents R7 is a high risk for falls. The most current Restraint: Side Rail Utilization Assessment, dated 9/15/2010, documents R7 uses quarter siderails to assist in positioning and/or transfers. The Side Rail Assessment documents R7 has no risk for the use of side rails except for a history of falls. The Assessment documents R7 does not attempt to get out of bed by climbing over or around the side rails. The Care Plan, dated 3/07/12, documents R7 "is at risk for falls due to history of falls while transferring unassisted, has impaired cognition and severely impaired balance. Interventions include, in part; "Assist with all transfers using assist of 2, remind her to call for assist with ADL's (activities of daily living) as needed, remind her	F9999		

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not to get up without assistance, side rails to assist with positioning and bed mobility, and wheelchair and bed mat alarms to be used at all times."

On 4/17/12, at 5:30 PM, R7 was observed to have a "T" shaped siderail attached at the center of her bed. The stem or center upright bar was 15.5 inches high and 16 inches wide. The crossbar on top was 32 inches wide and 10 inches high. There was an opening in the center upright bar 8 inches wide and 15 inches high. The cross bar had an 8 inch open area on each side. The right side of R7's bed was against the wall. According to the U.S. Food and Drug Administration publication, "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment - Guidance for Industry and FDA Staff", issued March 10, 2006; "to reduce the risk of head entrapment, openings in the bed system should not allow the widest part of the head to be trapped." The FDA uses a head breadth dimension of 4 3/4 inches as the basis for its dimensional limit recommentations.

On 4/17/12, at 5:35 PM, R7 was interviewed. R7 was confused. R7 reported she would not get out of bed without assistance. Then R7 reported if it was at night and she needed to use the bathroom, she would not want to bother anyone and would get up and use the bathroom.

The Nurses Note, dated 2/16/12, at 4:00 AM, documents R7 had "multiple attempts made to get out of bed. One on one given with success noted. Will monitor." During an interview on 4/18/12, at 10:00 AM, E2, Director of Nursing (DON) confirmed R7 has not fallen out of bed, but

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F9999	Continued From page 133 did try to get up unassisted before her last hospitalization in February 2012. E2 reported that R7's bed was donated to them, and the facility was not aware of the safety hazard of those particular siderails. E2 confirmed no other residents in the facility have the type of siderails as R7. The facility's policy and procedure, entitled, 'Fall Prevention Protocol' documents, in part, "This facility is committed to establishing guidelines and procedures to minimize the risk of falls and their effects so as to maximize every resident's well being. This standard dictates a mode of action to identify, assess and implement interventions for each resident and that facilitates an environment that is safe as possible." The policy identifies a type if fall as "Accidental: Falls that can be attributed to an environmental factor or mishap." The policy does not directly identify the use of side rails as a potential risk factor for resident injury or entrapment. 2. On 4/18/12 at 10:00 AM, R13's bed was found to have a canoe mattress and 2 half-rail length side rails attached to it. The side rails were in an up position, but leaning away from the side of the bed and were loose when moved back and forth. Additional padding for the rails was in the room, but not on the bed at this time. The right side of the bed was pushed up against the wall. On the left side of the bed, a gap between the bottom of the rail and the mattress was observed. At 10:10 AM, E69, Maintenance Director, came into the room with Z2, Corporate Compliance Officer, to look at the bed. The gap between the bottom of the siderail and R13's mattress was measured and found to be 5 inches wide. . According to the	F9999		

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F9999	Continued From page 134 U.S. Food and Drug Administration publication, "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment - Guidance for Industry and FDA Staff", issued March 10, 2006; "to reduce the risk of head entrapment, openings in the bed system should not allow the widest part of the head to be trapped." The FDA uses a head breadth dimension of 4 3/4 inches as the basis for its dimensional limit recommentations and under, "Zone 3 - Between the Rail and Mattress documents the dimension between the rail and the mattress should be less that 4 3/4 inches." At 9:30 AM, E2, Director of Nursing, came to the room, and indicated that the bed had been provided by R13's hospice provider to enable R13 to turn and position herself in bed. E2 indicated the rail pads were to keep R13 from becoming bruised on the rails. E2, indicated that with the pads added to the rails the space between the rail and mattress was smaller, approximately 3 inches, but not eliminated entirely. E2 stated that she did not think R13 was using the rails at this time, as she recently had fractured her right clavicle on 4/8/12, and could not turn on her own without assistance. A review of R13's care plan dated 4/9/12 indicated R13 was diagnosed with a right fractured clavicle, and was wearing a splint/brace on her right arm and shoulder that prevented her from positioning without assistance. (A) 300.610a) 300.1210b)	F9999		

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F9999	Continued From page 135 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. 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	F9999		

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F9999	Continued From page 136 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) Based on observation, interview and record review the facility failed to identify causative factors contributing to falls, accidents and injuries, implement interventions based on these identified factors, and failed to provide safe transfer techniques to prevent injury for 9 of 24 residents (R1, R3, R4, R5, R7, R12, R13, R22, R23) reviewed for falls and other safety concerns in the sample of 24 and two residents (R27 and R46) in the supplemental sample. This failure resulted in R13 sustaining a fracture to her right clavicle. 1. A review of an incident report dated 4/4/12, documented R13 had fallen from her bed onto the floor. R13 was not able to explain how she fell, and sustained a large bump to her fore head and bruising the right side of her face and right arm. On 4/8/12, the nurses notes documented R13 "moaning and grimacing when right shoulder touched. Purple and yellow discoloration to the shoulder, MD called." On 4/9/12 an X-ray revealed R13 had sustained "Subacute fracture of the distal third of the clavicle, no significant displacement." The most recent Minimum Data Set dated 3/29/12, documented R13 is moderately cognatively impaired, and needs assistance of at least 1 staff for all activities of daily living, transfers and mobility. R13 currently	F9999		

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(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
F9999	Continued From page 137 wears a splint / arm immobilizer on her right arm / shoulder. On 4/11/12 at 11:00 AM in an interview with E32, Licensed Practical Nurse, (LPN) stated "R13 had been in a canoe mattress prior to the fall. On 3/29/12, the mattress was changed to a low air loss mattress. The mattress had been fitted with bolsters on the sides to prevent falling. On 4/5/12 after R13's fall, the bed was examined by myself (E32) and the hospice owner, who determined the bolsters had been put on the bed backwards/upside down, and this allowed R13 to roll off the bed. We figured that when R13 got near the edge of the bed the bolsters did not stay upright, but some how flattened down and R13 rolled off the bed. Now R13 is back in the canoe bed she had before the fall." E32 stated "there is another resident on the 100 hall with the same bed, we checked his bolsters and they were okay. That is how we were able to see R13's bolsters were on wrong." On 4/13/12 at 10:15 AM, E6 and E23, both Corporate Nurses, indicated they thought the bolsters on R13's bed were applied "ok", but were not high enough to keep R13 in the bed. They thought R13 fell because the bolster being used was not the one recommended for the low air loss mattress, but a generic bolster the hospice company was using, that may not have been adequate enough for the low air loss mattress. On 4/13/12 at 1:30 PM, E2, Director of Nurses (DON), gave a written statement regarding R13's fall and documented, "On 4/4/12, (after R13's fall) I laid in the bed to try and determine how R13 rolled out. I did not feel the bolster was sufficient	F9999		

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	145585	A. BUILDING ______ B. WING ______	04/27/2012

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F9999	Continued From page 138 to keep R13 from rolling out. Called Hospice who came out and inspected the bolster mattress and stated he agreed that the bolster mattress may not prevent this resident from rolling out of bed again and the decision was made to change to the concave mattress. R13 has no history of falls, and the possibility that this could occur was unknown until the event." On 4/13/12 at 1:50 PM, E2 stated there was no policy regarding examining equipment for safety when brought in by an outside vendor. E2 indicated she felt R13's fall on 4/4/12 was and accident, and not the fault of the facility. 2. R13's nurses notes document she has a fractured right clavicle, and currently wears a splint / arm immobilizer on her right arm/shoulder. 4/11/12 at 9:40 AM, R13 was sitting in the hall outside the dining room. At that time, E31, Certified Nurses Aide (CNA), stated she would be putting R13 to bed soon. At 10:10 AM, R13 was in her bed. E31, stated that she had transferred R13 with a gait belt and the help of E35, CNA. E31 stated "R13 does not always bear weight and sometimes her knees buckle during the transfers." On 4/11/12, 10:25 AM, in an interview with E35, he stated "No, I have not been on the 100 hall this morning. I did not help E31 transfer R13 to bed this morning." At 10:30 AM, E31 stated, "I borrowed a belt from another staff, and transferred R13 by myself. She is a 1-person transfer in the care plan. I told you I had help to transfer R13 because I got nervous." A review of R13's care plan failed to show evidenceof documentation of any updates regarding how many staff are to assist R13 with transfers and	F9999		

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F9999	Continued From page 139 mobility while R13 has a fractured shoulder and is using a sling. On 4/11/12 at 11:30 AM, in an interview with E46, Rehab/Restorative Supervisor stated she was aware that R13 had a fractured shoulder, and wore a brace. E46 stated she had not been asked to assess R13 for appropriate assist with transfers since her fall. On 4/11/12 at 2:00 PM, E46 indicated she and E70 and E71, Physical Therapy Aides, had reviewed R13 for transfers. E46, E70, and E71 all agreed R13 should be a two person assist for transfers with gait belt. E46 stated, a two person transfer would be safest and prevent putting pressure on R13's arm and fractured right shoulder. All three staff E46, E70, and E71 indicated that they had not been asked to assess R13 for safety/transfer concerns since her fall, and that staff should not be transferring R13 alone. On 4/11/12 at 4:30 PM, E2, Director of Nursing, stated she had not been aware of E31's transferring R13 by herself and telling the surveyor that two staff had done the transfer. E2 stated she had no information on why R13 had not been assessed for safe transfers after diagnosed with a fracture. 3. On 4/18/12, R1 ' s bed had a metal side rail clamp attached to it. The clamp was attached to the frame, had sharp metal edges and was for holding a side rail in place. R1 had no side rails on her bed. The clamp was extending out from the bed frame 2 to 3 inches and had the potential to cause an injury should R1 fall or brush up against the bed frame.	F9999		

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F9999	Continued From page 140 4. A review of R7 ' s updated care plan dated 3/14/12 documented, " R7 is a great risk for falls due to history of falls, history of transferring unassisted, impaired cognition and severely impaired balance. Wheel chair and bed mat alarms to be used at all times, check placement each shift. On 4/10/12 and 4/11/12, at various times throughout the day when R7 was in her wheel chair, she was observed with no wheel chair alarm on. On 4/12/12, at 4:00 PM, E2 Director of nursing stated she did not know why staff had not checked to ensure the alarm was attached to R710. On 4/18/12, at 9:28 AM, R12 and R46 had half side rails on their beds. The side rails were made of hollow metal. Part of the side rails extended to the floor and had no end cap exposing sharp edges. 5. R22 was re-admitted to the facility on 1/19/11. R22's most recent Bed Rail Consent Form is dated 6/24/09. The consent form listed risks of using bed rails, including bruises, skin tears, fractures, entrapment with asphyxiation. Quarterly reviews on 2/24/11, 5/19/11 documented that siderails "continue to be indicated.". Side Rail Assessments dated 8/9/11, 11/l/11 1/18/13 were unchanged, with no changes, "At this time, side rails are indicated to assist with positioning/support." R22's Accident/Incident Reports from 7/11/11 until 2/4/12 documented six incidents with injuries due to hitting wheelchair arms and legs, hitting her siderails with arms and legs. On 8/16/11 at 10:30 AM, R22 had a skin tear measuring 2.8 cm by 0.6 cm. Steristrips were applied to the injury. The investigation documented, "Resident restless and attempted to get out of bed, hit leg on side	F9999		

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F9999	Continued From page 141 rail per CNA report.....". R22's Care Plan for Skin Breakdown documented the new intervention (in part), "......CNA reports res. restless attempted to get out of bed, hit leg on side rail.....". The intervention listed is to pad the leg rests of the wheelchair. The siderails are not addressed as a possible cause and no intervention involving the siderail was initiated. On 9/26/11 at 7:30 PM, E34, CNA, reported that she was putting R22 to bed. R22 became combative, kicking. E34 reported to the nurse, "Looks like someone took a chunk out of her leg....". R22 was sent to the Emergency Room and required 16 sutures to repair the laceration to her lower right leg. E2, Director of Nursing (DON), documented on 9/27/11 that, "Blood was noted on the frame of bed....It appeared that while CNA was putting resident to bed, she hit her leg on the bed frame. CNA counseled. Restorative Nurse to inservice CNA on proper transfers." On 11/14/11 at 8:00 AM, R22 was noted to have bruising to both arms. R22's Incident Report stated she is combative with care. Geri-sleeves were ordered and side rails were padded On 12/15/11 at 5:45 AM, E60, Night Nurse, noted a 4 cm. laceration to R22's right middle finger. Three steri-strips were applied. There are no new interventions following this incident. On 2/4/11 at 12:00 AM, E61, CNA, reported R22 obtained a skin tear. The incident report documented, "CNA stated resident resistive with care & hit hand on S/R (side rail) while repositioning." The skin tear measured 2 cm x 3	F9999		

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F9999	Continued From page 142 cm x 0.2 cm. The intervention listed is "given SR pads." There is no new intervention listed. There is no explanation why side rails were not padded since the incident dated 11/14/11 when side rail pads were first initiated. 6. R4's 8/29/11 Care Area Assessment (CAA) for falls documented (in part), that she has diagnoses of Rt. Tibia/Fibula Fracture, Anxiety, Alzheimer's with Dementia. R4 is incontinent of bowel and bladder, has restricted mobility, is transferred with a mechanical lift. She is a risk for falls. The facility's Incident/Accident Reports documented 6 falls/injuries since 7/1/11. On 12/26/11 at 10:35 AM, R4 had a contusion noted to her forehead above her left eye. The incident report documented that shower aides had bumped her face with the mechanical lift causing a contusion to her left forehead. The contusion was caused by facility staff's improper use of the mechanical lift, failure to prevent R4's head from hitting the frame of the mechanical lift. The intervention documented is "Shower CNAs counseled on safe use of (mechanical) lift." The facility's Policy and Procedures for Lifting and Transferring Residents dated 1/3/11 documented that "All residents requiring assistance with transfers will be lifted and/or transferred in a safe manner using appropriate support and equipment......Members of the nursing staff are responsible for using good body mechanics, knowing the proper transfer procedures and properly operating assistive devices."	F9999		

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F9999	Continued From page 143 7. R5's Fall Risk Assessment dated 3/8/12 assessed her as High Risk for falls with a score of 14. Score of 10 or above indicated a High Risk. R5's current Care Plan dated 12/14/11 documented that R5 requires extensive to total assist.....assist of two for transfers. She is at risk for falls d/t (due to) severely impaired balance. One intervention documented was, "Bed mat alarm at all times while in bed. Respond & reapply/reset as needed." On 4/10/12 at 1:40 PM, R5 was in bed. The bed was a canoe mattress in low position with a blue mat on the floor beside the bed. There was a sign posted on the wall above the bed stating "Bed Alarm". There was no bed alarm on the bed or on the mat beside the bed to alert staff that R5 was attempting to get out of bed. On 4/10/12 at 4:05 PM, R5 was transferred from the bed by E44 and E45, CNAs. R5 was assisted into a sitting position on the low bed. R5's sitting balance was poor. She was unable to stay in the sitting position without support from the CNAs. A gait belt was applied and E44 and E45 lifted R5 from the low bed, using the gait belt and their arms hooked under R5's arms. R5 was lifted out of the bed, with her weight suspended from her axilla. Her feet did not touch the floor, as she was lifted out of the bed and placed into the geriatric recliner with a pommel cushion in the seat. Both CNAs confirmed that R5 was unable to bear weight. 8. On 4/10/11 at 11:40 AM in the main dining room, R27 was seated in a wheelchair with a Pommel cushion. There were no staff next to her.	F9999		

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F9999	Continued From page 144	F9999		

R27's laptop cushion on the floor next to her wheelchair. R27 began to propel herself away from the table and towards the door. There was a sign posted next to the exit door in the dining room which documented "Attention Staff: Do not remove (laptop cushions) at mealtime until staff are sitting with residents."

9. On 4/18/12, at 9:28 AM, R12 and R46 had half side rails on their beds. The side rails were made of hollow horizontal and vertical metal bars. The vertical ends of the side rails had sharp edges with no caps on the ends to prevent a resident from being accidentally cut on them.

10. R3's Physician's Order Sheet (POS) for April 2012, documents an order for R3 to wear (skin protector) sleeves to all extremities. The facility's Management PCE (Patient Care Event) Tracking Log documents R3 has a history of skin tears on 3/31/12, 2/25/12, and 10/27/11.

On 4/10/12 at 1:55 PM, R3 was observed with a gauze dressing to her left lower leg. R3 did not have skin protector sleeves on any of her extremities.

On 4/20/12 at 8:15 AM, E1, Administrator, stated R3 "should have (skin protector) sleeves on all extremities. It might have been that they were being laundered."