Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		IL6004816	B. WING		08/1	; 4/2014	
NAME OF	PROVIDER OR SUPPLIER	1	<u></u>	STATE, ZIP CODE	1 00/1	4/2014	
REHAB	REHAB & CARE CTR - JACKSON CO 1441 NORTH 14TH STREET MURPHYSBORO, IL 62966						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ACTION SHOULD BE COMPLETE DATE		
S9999	Final Observations		S9999				
	Statement of Licens	sure Violations:					
	300.1210b) 300.1210d)6) 300.3240a)		PROTECTION OF THE PROTECTION O				
	Section 300.1210 G Nursing and Persor	General Requirements for nal 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 sub care shall include, a and shall be practic seven-day-a-week b						
	assure that the residual as free of accident I nursing personnel s	recautions shall be taken to dents' environment remains nazards as possible. All hall evaluate residents to see eceives adequate supervision revent accidents.					
	Section 300.3240 A	buse and Neglect	The state of the s				
		ee, administrator, employee or					

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

STATE FORM 6899 WUMW11 If continuation sheet 1 of 4

PRINTED: 09/10/2014

FORM APPROVED Illinois Department of Public Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ C B. WING IL6004816 08/14/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1441 NORTH 14TH STREET **REHAB & CARE CTR - JACKSON CO** MURPHYSBORO, IL 62966 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PRÉFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) S9999 Continued From page 1 S9999 resident. (Section 2-107 of the Act) These Regulations were not met as evidenced Based on observation, record review and interview the facility failed to appropriately transfer one resident (R3) reviewed for falls. This failure resulted in a mildly displaced fracture of left distal tibia and fibula. Findings include: R3 is 88 years old with diagnosis of Alzheimer's; Dysphasia; Dementia with Behavioral Disturbance: Depressive Disorder: Stage III Pressure on Coccyx; Gout: Fibula Fracture; and Chronic Kidney Disease according to the Admission Record dated January 23, 2013. R3's Minimum Data Sets (MDS) dated March 25, 2014 and June 24, 2014 indicates R3 is is totally dependent with two persons physical assistance for transferring between surfaces including to and from bed, chair, wheel chair, and standing positions, these same MDS's evaluate R3 as moderately impaired for cognitive skills for daily decision making. The incident log for 11:00 PM to 7:00 AM shift for March 2014 lists R3 as having a fracture. An x-ray report dated March 16, 2014 states " nondisplaced fracture of distal fibula" and "Irregularity of the lateral malieolus is identified.

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This may indicate a nondisplaced fracture." and a followup x-ray report dated April 21, 2014 states " mildly displaced fracture distal tibia and fibula."

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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	IL6004816		B. WING		08/14/2014	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
REHAB	& CARE CTR - JACKS	SUN LU	TH 14TH ST SBORO, IL			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
W 1 10 10 10 10 10 10 10 10 10 10 10 10 1	The facilities internal lists E10 (Certified I R3 to bed on March from other staff. The Summary of Care Sperson transfer, and of Care sheet lists F both sheets dated INE 10 wrote on an em March 16, 2014, "In transfer was made to chair without assistate to the bed after supplindicated E10 was reperson transfer, at the Statement form the knew a resident had reported to the charmant some to touch or in parch 25, and March 26, and NORCO 5-3 On August 14, 2014 receiving a disciplinal alone but again state room to indicate a the required. E1 verified provided to E10 for the information of R3 netransferring was ava Summary of Care Si	al investigation of R3's fracture Nurses Aide [CNA]) as putting 15, 2014 without assistance e Certified Nurses Aide (CNA) sheet indicates R3 as a 2 di the Charge Nurse Summary R2 as a 2 person transfer, March 14, 2014, 1:52 PM. Inployee statement dated elp could not be located and a from R3's bed to the wheel ance, and from the wheelchair per meal", the statement also not aware R3 was a two he bottom of the Employee statement was written "If I if fracture, I would have ge nurse immediately." Indicate the left ankle was ain on March 20, March 21, th 29, 2014 and R3 was cation MAPAP 2 tabs (650 March 16, once one March 1825 on March 17, 2014. at 11:00 AM, E10 reported any action for transferring R3 and there was nothing in R3's to person transfer was a disciplinary action was transferring R3 alone and the reding 2 persons for ilable to E10 on the CNA neet available to all CNA's.	\$9999			
	2014 at 10:30 AM, a	o occasions, August 12, nd August 13, 2014 at11:00				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		IL6004816	B. WING		08/14	1/2014	
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REHAB & CARE CTR - JACKSON CO 1441 NORTH 14TH STREET MURPHYSBORO, IL 62966							
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CONTROL CO		(X5) COMPLETE DATE	
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