

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2014
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NAME OF PROVIDER OR SUPPLIER DOUGLAS NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3516 POWELL LANE MATTOON, IL 61938
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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) COMPLETE DATE
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S9999	<p>Final Observations</p> <p>Statement of Licensure Violations:</p> <p>300.610a) 300.1210b) 300.1210d)6) 300.3240a)</p> <p>Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.</p> <p>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.</p> <p>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:</p>	S9999		
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Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	<p>Continued From page 1</p> <p>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.</p> <p>Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>These requirements are not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure the safety/supervision to prevent falls by failing to supervise a resident in bed and and failing use correct placement of the gait belt for two of four residents (R10, R4) reviewed for falls/safety from the sample of ten. The facility failed to take precautions to prevent R10 from rolling off of the bed which resulted in R10 sustaining a fracture of the left elbow. Findings include:</p> <p>1. On 7/23/14 at 11:00 AM, E14 Certified Nursing Assistant (CNA) stated that on 6/15/14 E14 was providing incontinence care with assistance from E15 CNA to R10. E14 and E15 assisted R10 to roll into a left side lying position. E15 told E14 that E15 was leaving the room to obtain more linens. When E15 stepped away from the bedside, E15 left the siderail up in the vertical position, instead of the horizontal position. E14 by stated that R10 then rolled off of the bed and onto the floor.</p> <p>The witness statement form by E15 dated 6/15/14 documents "I stated that I was going to get a gown. I stepped away from the bed starting</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>towards the door when I heard [E14] yell [R10]. I turned around and [R10] was in the process of rolling off the bed."</p> <p>The Medical History report for Laboratory/X-Rays dated 6/15/14 documents R10 experienced a fracture of the left elbow as a result of this fall.</p> <p>The facility's undated Perineal Care policy documents that staff are to assemble needed equipment and supplies as preparation prior to the procedure of providing incontinence care, and to make sure staff "has adequate assistance to safely and comfortably perform the procedure."</p> <p>On 7/23/14 E1 Administrator stated that R10's fall was "staff failure. The CNA behind the resident [E14] should have been the one to go get extra linens, or the CNA in front of the resident [E15] should have put the siderail to the down [horizontal] position, or they could have placed the resident on [R10's] back."</p> <p>The facility's Occurrence Investigation Report dated 6/15/14 documents the root cause of R10's fall on 6/15/14 as being "human error" and concluded that "CNA's [E14 and E15] did not have the rails in the down position and left resident to get supplies. Resident rolled off [R10's] side onto the floor."</p> <p>2. R4's Physicians Order Sheet dated July 2014 document diagnoses of Osteoporosis and Right Hip Fracture.</p> <p>On 7/21/14 at 11:37 am E5 and E11, Certified Nursing Assistants (CNA) placed a gait belt under R4' arm pits. As the CNA's assisted R4 to a</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>standing position R4 stated "my legs are giving out". E5 and E11 continued the transfer and carried R4 from the bed, three feet to the wheel chair by the gait belt under R4's arms. With her legs stretched out and toes pointed towards the floor, R4's feet never touched the floor. At this time, while touching the gait belt, R4 stated " they always put this thing up here." E11 stated "We always place the gait belt high because her breast hang down." At 11:44 am E10 Licensed Practical Nurse (LPN) entered R4's room and stated " the gait belt goes around the waist."</p> <p>On 7/22/14 at 1:23 pm E13 Physical Therapy Program Director stated that he teaches the Nurses and CNAs to place the gait belt snug around the waist and if the breast are large and in the way, the resident should be asked to lift them up for proper placement of the gait belt.</p> <p>The facility transfer policy dated 7/22/14 documents " It is the policy of this facility to provide a safe environment, given to all CNA's upon hire."</p> <p>(B)</p>	S9999		