STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145713	A. BUILDING _____ B. WING _____	C 05/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOMENCE MEADOWS NURSING & REHAB	**500 SOUTH WALNUT MOMENCE, IL 60954**

(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 000	INITIAL COMMENTS Complaint Investigation 1672674/ IL 85562	F 000		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to implement fall prevention interventions and safety measures for residents with history of falling. This applies to 1 resident out of 3 (R2) reviewed for falls and safety. Findings include: Review of the facility's Incident Log showed: R2 experience a fall occurrence on March 9, 2016 at 5:48 PM, March 29, 2016 at 6:13 PM and March 31, 2016 at 3:08 PM. E2 (director of nursing) was interviewed on May 24, 2016 at 2:31 PM. E2 said R2 is very impulsive and is at risk for falls. E2 stated, R2 will try to put himself to bed from wheel chair, or from the bed to the wheel chair. E2 said R2 can stand, but he's unsteady on his feet. E2 stated	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 323	Continued From page 1	F 323		

R2 last fall occurred 3/31/2016, while attempting to transfer from the wheel chair to bed. Then, E2 went to R2's bedside to show fall safety measures put in place to prevent R2 from falling. R2 was observed in bed, alert, restless and moving about. R2's bed linen was bundle up and he had his top covers off. R2 was wearing only a shirt and adult incontinent pad. R2 told E2 he wanted to get up. R2 had a call light, but it was observed on the floor out of his reach. E2 said it was a special call made for him to easily use, but E2 did not explain why R2's call light was on the floor. R2 had a half metal side rail that was partly attached to his bed, and hanging on the side of his bed. E2 could not explain why R2's side rail was partly attached to his bed and hanging half way off. E2 said R2 used the side rail to reposition himself in bed. E2 stated R2 had the half rail to move about in bed. E2 said R2 had a bed alarm to alert staff when he tried to get out of bed. E2 was asked to show that R2's bed alarm was functioning. R2 was made to stand with help of E2 and a CNA (certified nurse aid), but R2's bed alarm was not observed to sound and function. E2 looked at R2's bed alarm and stated R2's bed alarm battery was low and it not working. E2 said resident's bed alarms are checked daily, but she (E2) could not explain why no one notice R2's bed alarm was not working.

On May 24, 2016 at 4:01PM, R2 was observed sitting in a wheel chair by his bed and staff was not present in the room. R2 kept pulling on his bed side rail, trying to pull himself out of his wheel chair. E12 (Nurse Aid) was passing in the hallway and was asked to assist R2. E12 said that R2 frequently would get away from staff attempting to keep him busy in the dining room. E12 stated R2 should not be left alone in his

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F 323	Continued From page 2	F 323		

room, because R2 will try to pull himself out of his wheel chair into bed by using his side rails. E12 said this is the number one reason he (R2) falls by pulling on the side rail to transfer himself from the wheel chair. E12 stated we try to keep up with R2, but sometimes he gets away from us (CNA's).

E3 (nurse) was interviewed on May 25, 2016 at 1:35PM and E3 said he has taken care of R2 before and described R2 wanting to transfer himself. E3 stated R2 will not wait for staff, but will try to get up by himself. E3 said R2 needs help to safety transfer.

Review of R2's Face Sheet, dated May 25, 2016, showed R2 is a 79 year old male, who was admitted to the facility on 8/22/2011. R2 had diagnosis including: Dementia, Generalized Muscle Weakness, Lack of Coordination, and History of Falls.

Review of R2's most recent fall risk assessment, dated April 21, 2016, showed R2 had problems with memory and recall, and agitated behaviors. An analysis of R2's gait showed he exhibits loss of balance while standing and requires hands on assist to move place to place. This assessment determined R2 was at high risk for falls.

Review of R2's Physician Order Sheet, dated May 25, 2016, showed the following active orders: May have 2 1/2 side rails for bed mobility... Clip alarm to wheel chair and pressure alarm to bed. Check function and placement every shift..." R2's bed alarm battery was noted to be low and nonfunctional on May 24, 2016.

Review of R2's care plan, dated April 21, 2016,

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F 323	Continued From page 3 showed R2 was at risk for falls related to: "...History of Falls, Impulsiveness with attempts to stand or self-transfer without assistance from the staff... Requires ADL (Activities of Daily Living) for Transfers and Mobility..." The goal of R2's care plan: "Will have a safe environment maintained thru next review... 7/28/2016" The nursing interventions identified to achieve this goal were: Be sure call light within reach... Pressure Alarm to bed and while in chair..." These interventions were not implemented during the observations.	F 323		