STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146058	A. BUILDING _____ B. WING _____	C 05/06/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVANSTON NURSING & REHAB CTR	**1300 OAK AVENUE EVANSTON, IL 60201**

(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 0991713/IL40986 No extended survey was conducted.	F 000		
F 323 SS=G	483.25(h) ACCIDENTS AND SUPERVISION 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 observation, interview and record review the facility failed to ensure the safety of the resident through proper handling of the resident during care, safe equipment and failed to properly assess for one out 3 residents sampled (R2). R2 has a history of falling between the bed and the wall while in bed that was placed next to a wall. The lack of preventive action, proper assistance and the lack of proper bed maintenance to ensure stability led to R2 falling again from bed between the bed and the wall during care causing fracture of shoulder, pain and discomfort. Findings include: -The facility's Incident Report included an incident dated 04/14/09 2 PM. The Incident	F 323		

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

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F 323	Continued From page 1 Report contained the following information: Description of Incident: Nurses aid reported to E3 (Nurse) that R2 slide off from her bed on the floor while doing resident's care. Description of injury: No visible injury noted. Interventions: Tylenol 650 mg given for complained mild pain to left side of hand and shoulder. - Post Fall Assessment: Is resident able to recall the reason for the fall? Yes If yes, provide resident's response:" I turned and slide off from my bed onto the floor." Management Follow-up to Incidents included: -Interview with resident: Resident stated when she turned, slid out of the bed. Intially stated " I'm okay" but then stated my arm hurts, pointing to her left arm. -Interview with staff : According to CNA (Certified Nursing Assistant), she was cleaning her and ask the resident to turn. When the resident turned, resident slid to the floor. Assessment was done. No visible injury observed. MD (Physician) was paged, son notified message left by nurse. -Interdisciplinary Interventions: Fall assessment, pain assessment reviewed. Bed was checked, brakes was okay. Staff interviewed. R2 has had previous fall between the bed and the wall occurring on 10/28/08. In the description	F 323		

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F 323	Continued From page 2 of the fall, R2 expressed the she was trying to push the bed further to the right (away from the wall) and she slipped out of bed. This reflect that the bed was placed next to her wall and that the breaks did not work at that time. During that time, there were no follow up on the safety of the bed such as testing to see if the breaks could be applied to prevent the bed from moving away when the wall is pushed. There were no care plan update noted after the fall. R2 has diagnoses that CVA (Cerebro Vascular Accident) with left sided weakness, Seizure Disorder, history of distal Fibula/Tibia fracture Diabetes Mellitus, Hypertension, Depression, Glaucoma and Osteoarthritis. On 04/24/09 at 12:35 AM E4, stated "R2 was in bed and it's time for rounds. E5 was the CNA and I was just assisting. E5 was getting water/soap/towel in the bathroom. I was standing near the door at the foot part of R2's bed. R2 was laying on her back ans E5 CNA is coming from bathroom to R2's bed holding the wet towel/diaper. I was still standing at the foot of the bed when I told R2 to turn over which she can do. R2 turned over towards the wall on her left side.When R2 turned over she started to slide between the bed and the wall which grabbing her leg won't help. By that time, R2 was already on the floor. R2 turned fast and usually does that at times. R2 ended on the floor laying on her side (weak side). We moved the bed to the side after R2 was on the floor. The bed moved about 20 degrees." Surveyor asked if the bed was locked? E5 replied " I don't think so because the bed won't moved if the wheels were locked. R2 does not need assist in turning towards the wall which is R2's left side but needs assist in turning on the	F 323		

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F 323	Continued From page 3 right side. R2 was on the floor and we called E3 (nurse). E3 came in and asked R2 if okay or in pain. R2 said, "no, I'm okay". We (E4 and E5) tried to get R2 up but we were not successful. We called the nurse again. E3 came in and assist to pick up R2 off the floor. When R2 was in bed, E3 asked R2 again. Are you okay or in pain? R2 said " No, my left arm hurt." R2 was in bed and took vital signs. E3 called the physician and E5 changed R2's incontinent pads." On 04/24/09 at 1:05 PM E5 CNA, was also interviewed. E5 stated " I was the CNA. After lunch I put R2 back in bed. E4 was with me. E4 was at the foot part of R2's bed. Bed was against the wall. I asked R2 to turn toward the wall and R2 completely on her stomach and slide behind the bed towards the wall. The bed was moving and E4 was trying to stop the bed so R2 won't slide behind the bed. R2 slid behind the bed and went down on the floor on R2's right side. I informed E3 and he came in. E3 asked R2 if she was okay or was hurt. R2 said "No." We (E4 and E5) tried to lift R2 up but R2 was too heavy so i called E3 again. E3 helped us to put R2 back to bed. I changed and left R2 in bed." On 04/24/09 at 3 PM E3 (Nurse) stated " A CNA came up and told me that R2 slipped off from the bed between the wall and the bed. I went to the room and R2 was laying down on the floor on right side. I asked R2 are you okay or in pain. R2 said "No." I did not touch R2. I went back to the nursing station to cover my papers/ my notes. Took gloves went to room 208 and R2 was on her back. I asked R2 again. Are you okay? R2 said, I'm okay. I checked for any bruises then later we (E4 and E5) assist R2 back to bed. R2 has left side paralysis. I went back the second	F 323		

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F 323	Continued From page 4	F 323		

time and asked the CNA to take vital signs. After putting R2 in bed, I checked the legs, hands and whole body. We (E4 and E5) lifted R2 back in bed. I went back asked R2 if in any pain. R2 said left side hurts so I called the Physician. Physician order to give Tylenol, observe and notify the physician for any changes."

Nurses notes reflect on the following dates that:

- On 04/14/09 at 2:30 PM -"Nurses Aide reported to E3 that R2 slide out of bed unto the floor while doing care. Physician was notified. E2 DON (Director of Nursing) made aware. Attempt to reach son unsuccessful. Tylenol 650 mg given for c/o (complain of) pain to R2's left hand. On 72 hour PIC (Post Incident Charting). Vital signs B/P 163/84, Pulse 80, R18, T97.6 Will continue to give Tylenol. Tylenol 650 mg given for c/o (complain of) left sided pain. Kept dry and clean. In bed and made comfortable."

- On 04/15/09 at 1:30 PM- "Resident is alert and oriented X3. Up in w/c (wheel chair. C/O (complain of) left hand pain but refuses any pain medication. Physician order X-ray to left hand. X-ray done to left hand. Result pending."

- On 04/15/09 3-11 PM - "X-ray report per verbally, left shoulder fracture. AP (Attending Physician)paged. AP returned call with order to send to ER (Emegency Room) for evaluation."

- On 04/16/09 7 AM-"Left shoulder Fx. (fracture). Left shoulder immobilizer in place. Returned at 2:30 AM. Alert. No c/o (complain of) pain."

R2 complained of left hand pain but R2 refuses any pain medication. MD ordered X-ray to left

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F 323	Continued From page 5 hand. -04/15/09 3-11 PM : X-ray report reflect left shoulder fracture. MD notified and R2 was sent to hospital for evaluation. Per Hospital ER report dated 04/15/09 showed that R2 had Fractured shoulder. Review of MDS (Minimum Data set) Assessment showed that R2's bed mobility is coded 3/2. This means that R2 needs extensive assistance with one assist in bed mobility. On 04/24/09 at 1;30 PM surveyor asked E5 to demonstrate how R2 turned from bed. E5 laid in the bed used by R2 when she fell. The bed was positioned against the wall as it was during the incident. E5 re-enacted what she observed during the incident. E5 demonstrated by turning to her side towards the wall and overturned. E5's momentum moved the bed away from the wall just as it happened on the incident. E5 actually slid off the bed, between the bed and the wall and ended on the floor. Surveyor checked R2's bed. R2's bed has locks on the wheels on the side away from the wall and no wheel locks on the wall side. Both wheel locks were on unlocked position during the demonstration. E5 then put the wheels on a lock position and tested the bed. The bed continued to move away from the wall with the same amount of effort as on unlocked position. E6, the maintenace supervisor also came to check the bed to see if bed can be stabilized. E6 checked the locks but bed continued to move away from wall even after E6 applied the locks. Other beds were checked with E2. Beds on room 215, 210	F 323		

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F 323	Continued From page 6 bed 1 and 2, 208 bed 1, 210 bed 2, 205, 201 and 217 and 201 were also checked and the beds were moving even when they are locked. Room 211 has no locks. Review of maintenace record show that the safety of R2's bed and these beds were not checked for stability. The facility did not review staff handling of R2 who was identified by her assessment as needing assistance. There were no preventive action. The facility did not assess resident's safety whose bed was placed against the wall. Most of the beds noted were placed next to a wall and residents are still being put to bed on these unsafe conditions.	F 323		