STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001341	A. BUILDING: _____ B. WING _____	C 02/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
S9999	Final Observations Statement of licensure violations: 300.610a) 300.1010h 300.1210b) 300.1210d)5) 300.1220b)3) 300.1620a) 300.3240a) 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. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care	S9999	Attachment A Statement of Licensure Violations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001341	A. BUILDING: _____ B. WING _____	C 02/17/2015

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S9999	Continued From page 1 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: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as	S9999		

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S9999	Continued From page 2 indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.1620 Compliance with Licensed Prescriber's Orders a) All medications shall be given only upon the written, facsimile or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All such orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time 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 interviews, observations and record review, the facility failed to development a preventative plan for pressure ulcers, identify, assess, monitor and treat pressure ulcers in a timely manner for 4 of 4 residents (R5, R7, R8 and R10) reviewed for pressure ulcers in a sample of 13. This failure resulted in R5 developing facility acquired unstageable pressure ulcer to her left heel, a Stage II pressure ulcer to her left ear and and an unstageable pressure ulcer to her coccyx. R5's pressure ulcer on her ear deteriorated to a Stage IV. Findings include:	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 3	S9999		

1. R5's January 2015, Physician Order Sheet (POS) documents R5 was admitted to the facility on 1/8/15.

R5's BRADEN SCALE - For Predicting Pressure Sore Risk of 1/8/15 documents a score of 11 which is high risk and on 1/22/15 a score of 10 which is high risk.

R5's Admission Resident - Data Collection report of 1/8/15 documents R5 has a reddened coccyx with skin intact. There is no other documentation of skin breakdown.

R5's undated Interim Plan of Care documents R5 requires total care and has a reddened coccyx. R5's Care Plan approach is to keep R5 clean, dry and safe.

R5's Comprehensive Admission Skin Assessment of 1/8/15 documents reddened area on the coccyx. The Assessment documents "Pressure ulcer prevention. Keep pt (patient) clean & dry, q (every 2 hours)." There are no other prevention interventions for pressure ulcers identified on the assessment.

The TAR documents R5 was admitted on 1/8/15 and R5 was to have weekly skin assessment. R5's January 2015 Treatment Administration Record (TAR) documents the 1/17/15 Weekly Skin Assessment was completed and R5's skin was warm, dry and color fair. No edema. The Assessment documented R5 had contractures to bilateral hands and foot drop to bilateral feet. No areas of concern were noted. Note of 1/28/15 documents "Skin warm dry, open areas noted on coccyx and left and right buttock, treatment ordered." The TAR documents skin checks were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001341	A. BUILDING: _____ B. WING _____	C 02/17/2015

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S9999	Continued From page 4	S9999		

only done on 1/17/15 and 1/28/15 in the month of January.

R5's WOUND CARE SPECIALIST INITIAL EVALUATION done by Z1, Wound Doctor, dated 1/28/15 documents the following pressure sores:

1. An unstageable DTI (Deep Tissue Injury) to the left heel measuring 3 centimeters (cm) x (by) 3 cm with recommendation for heel boot to be worn in bed and chair to off-load wound, float heels in bed and off-load wound.
2. Stage 2 pressure ulcer to the left ear measuring .5 cm x .5 cm x .1 cm with light sero sanguineous drainage. Dressing: Dry Protective Dressing - once Daily and PRN (as needed). Off-load wound.
3. Unstageable (Due to Necrosis) of the coccyx measuring 4 cm x 2 cm with depth not measurable. Light serous exudate. Noted as reddened area upon admission. Dressing: Santyl - Twice daily and PRN. Dry Protective Dressing twice daily and prn. Antifungal - twice daily and PRN. Off load wound, reposition per facility protocol.
4. Z1 ordered a pre-albumin for R5. The results of the pre albumin of 1/30/15 documents Pre-albumin of 17.5 mg/dl (milligrams)/dl (deciliter) with normal being (16-45).

On 1/30/2015 at approximately 3:00 PM, R5's TAR was copied and did not have documentation on the TAR of the above pressure ulcers and treatment orders.

On 1/30/15 at 11:17 AM, E3, Licensed Practical Nurse, LPN, completed a skin check while R5 was in bed. R5 had heel protectors on her feet but feet were not off loaded from the mattress.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001341	A. BUILDING: _____ B. WING _____	C 02/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST REHAB & RESPIRATORY	727 NORTH 17TH STREET BELLEVILLE, IL 62226

(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
S9999	Continued From page 5	S9999		

There was a purple pressure sore larger than an inch on her left foot. R5 had an open pressure sore with yellow center on her coccyx. R5 did not have a dressing on her coccyx and she had feces at the anal area. R5 had a scab and dried blood on her outer left ear that did not have a dressing. R5's right hand had red opened areas on her 1st finger and third finger and a scab on her thumb. At 11:20PM, E6 and E8, Certified Nurse's Assistants, CNA's, stated they were the CNA's that were caring for R5. They stated they had last given care to R5 at 8:00 AM and R5 did not have any dressing on her ear or coccyx at that time. There was no dressing in R5's bed or under the bed or in the surrounding area. E8 gave R5 incontinent care and using the same soiled gloves put barrier cream on R5's buttocks and coccyx.

An observation was made with E1, Administrator, on 1/30/2015 at 2:30 PM. R5 was in bed and still had no dressing on her coccyx/buttock area or ear. R5 did have heel protectors on but her heels were not floated. There was no dressing on R5's ear and E1 was informed of the areas on R5's right hand. At 2:45 PM, E1 stated that they had found R5's bandage for her left ear in her bed but staff were not taping on the bandage and she didn't know why.

On 2/4/2015, at 9:45 AM R5 was in bed. Skin check with E1 showed R5 did not have a dressing on her left ear and there was blood on her pillow case. E1 did not have heels floated. E1 did have a bandage over her buttocks and coccyx area and was incontinent of a large amount of feces. The bandage did not have a time or date documented as to when it was applied.

On 2/4/15 at approximately 10:00 AM, E2,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001341	A. BUILDING: _____ B. WING _____	C 02/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST REHAB & RESPIRATORY	727 NORTH 17TH STREET BELLEVILLE, IL 62226

(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
S9999	Continued From page 6	S9999		

Director of Nursing (DON), was asked for a copy of R5's January TAR. The TAR documented an order for Santyl and cover with dry dressing BID (twice daily) and PRN. The TAR shows no initials that the treatment was done. The TAR documents "Apply Skin Prep to left heel BID" with documentation that it was applied only one day, 1/29, but not applied on 1/28/15, 1/30/15 or 1/31/15. There was nothing on the TAR about floating the heels. The TAR showed order of 1/28/15 to apply dry dressing to the left ear every day and PRN with no documentation that this was being done. There is no documentation on the TAR for February 2015 that the above treatments were being done.

Z1's WOUND CARE SPECIALIST EVALUATION done on 2/4/15 documents that R5's pressure ulcer on her left ear had increased in size to "1 cm x .5 cm x .1 cm and is a stage 4 with surgical excisional debridement of muscle. Continue dry protective dressing once daily and PRN. Mupirocin once daily and PRN. Off-load wound."

Z1 stated on 2/4/15 at 11:35 AM, R5's wounds on her coccyx, ears and heel is from pressure and she would expect the dressings to be on. Z1 stated that the dressing on R5's ear should be taped. The pressure sore is chronic and down to the cartilage. Z1 stated R5 favors laying on her left ear and needs to be kept off the ear or it won't heel. Z1 stated she is ordering special ear protectors for R5.

On 2/6/2015, at 2:20 PM, an interview was conducted with E10, Assistant Director of Nurses/Wound Nurse. E10 confirmed R5's TAR did not have any documented orders/ treatments for R5's ear or coccyx until 2/4/2015. E10 stated that the floor nurses would not know to do the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001341	A. BUILDING: _____ B. WING _____	C 02/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST REHAB & RESPIRATORY	727 NORTH 17TH STREET BELLEVILLE, IL 62226

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S9999	Continued From page 7	S9999		

treatments unless the orders were on the TAR. E10 stated if the treatments on the TAR are not initialed as completed then the treatment was not completed. E10 stated it is Nursing Standard of Practice to document/initial the TAR after completing a treatment.

On 2/6/2015, at 2:30 PM, an interview was conducted with E3. E3 stated the nurses typically look at the TAR to see if a resident has a treatment. E3 stated once the treatment is complete, the nurse would initial the date and time the treatment was competed on the TAR. E3 stated if a physician gives an order for a treatment, the treatment is put on the TAR. E3 stated if you know the resident had an opened area and the treatment was not on the TAR, you would check the order and add the order to that resident's TAR. When questioned if a signature is missing on a TAR, E3 responded "It's either you forgot to sign it or you didn't do it."

On 2/6/2015, at 2:45 PM, an interview was conducted with E12, Corporate Nurse. E12 stated the TARS should reflect the treatment orders for each residents. E12 stated "That's how you know." E12 stated if nurse's do not initial the TAR then you can assume the treatment was not done.

R5's Care Plan of 1/22/15 and revised on 2/3/15 does not address R5's Pressure Ulcers. The Care Plan does not address R5's risks for pressure ulcers and interventions to aide in healing existing pressure sores or the prevention of developing new pressure ulcers.

The Facility's Decubitus Care/Pressure Area Policy, reviewed January 2014, documents "To ensure a proper treatment program has been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001341	A. BUILDING: _____ B. WING _____	C 02/17/2015

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S9999	Continued From page 8	S9999		

instituted and is being closerly monitored to promote the healing of any pressure ulcer, once identified." The Policy documents "1) The pressure area will be assessed and documented." The Policy documents "3) Notify the physician for treatment orders. The physician's orders may include: i) Type of treatment; ii) Frequency treatment is to be performed; iii) How to cleanse, if needed; iv) Site of application; v) No PRN order is acceptable for a pressure ulcer. The order must have specific frequencies; vi) Initiate physician order on treatment sheet."

2. The MDS dated 12/18/14 identifies R10 as totally dependent on staff for all activities of daily living. The MDS documents diagnoses to include Acute Respiratory Failure, Urinary Tract Infection, Sepsis, Anoxic Brain Damage among others. R10's POS documents R10 has a tracheostomy and gastrostomy tube.

The Braden Scale dated 1/9/15 identifies R10 at high risk for pressure ulcer development. The Braden Scale dated 12/29/14 identifies R10 as high risk for pressure ulcers.

R10's laboratory results dated 1/30/15 reflects normal Protein 6.3 (Normal 6-8.2) and Albumin 3.5 (Normal 3.5-5,5) and Pre-Albumin dated 2/5/15 was also normal at 22 (normal 16-45.)

The Weekly Pressure Ulcer Record dated 12/10/14 identifies R10 as having multiple pressure ulcers at that time and the Weekly skin reports also document a pressure ulcer on left heel. Treatment orders are present on the POS January and February 2015 for all three areas. The care plan dated 12/29/14 does not include a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001341	A. BUILDING: _____ B. WING _____	C 02/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST REHAB & RESPIRATORY	727 NORTH 17TH STREET BELLEVILLE, IL 62226

(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
S9999	Continued From page 9	S9999		

prevention plan nor a treatment plan for R10's pressure ulcers.

R10's weekly wound documentation dated 12/10/14 identify it as the first evaluation by Z1 for R10's Elbow Ulcer. Measurements were "3.5 cm x 2.5 cm x 1cm stage 3 duration less than 6 days, undermining 1cm at 9 o'clock, moderate Serous exudate, 5% necrosis and 95% granulation." Weekly Skin Reports dated 12/17/14 and 12/24/14 show minimal change with Z1 documenting the area as "healing". Recommendation for all visits was to off load. On 1/14/15, R10's weekly wound report for the elbow ulcer continues to document it as a stage 3 with 100% granulation with the area measuring 2.5 cm x 2.5 cm x 1 cm.

Weekly report narrative, dated 1/21/15, written by Z1 documents that R10's elbow pressure ulcer has deteriorated due to infection, wound not adequately off-loaded, measurements were 4 cm x 3 cm x1 cm, wound progress "deteriorated". The Weekly wound care notes, dated 1/28/15, by Z1 document the same measurements as before but indicates there is moderate purulent exudate with the elbow wound, 30% necrotic tissue. The report documents a surgical excisional debridement of the subcuteaneous tissue was done. On 2/4/15, Z1 documented R10's elbow pressure ulcer was stage IV with no other changes.

On 1/30/15 at 10:00 AM, R10 was laying in bed on her back with her elbows resting on wedge cushions under both elbows. R10's knees were drawn up in contractures and her arms were pulled inward. At 10:30 AM, 11:05 AM, 11:35 AM, 12:00 PM, 12:30 PM and 1:00 PM, R10 remained in the same position with the head of the bed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001341	A. BUILDING: _____ B. WING _____	C 02/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST REHAB & RESPIRATORY	727 NORTH 17TH STREET BELLEVILLE, IL 62226

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S9999	Continued From page 10	S9999		

elevated until 1:30 PM. At 1:35 PM, a skin check was done with E3 LPN and E6,CNA. R10 was laying on her back, knees and arms contracted, with her left elbow resting directly on the wedge cushion to her left side. R10's elbow dressing was loose and saturated with a blood tinged drainage which had saturated the incontinent pad under R10's elbow as well. R10 had a incontinent brief under her which had smears of dried bowel movement on it along with a large area of urine which E6 CNA identified as urine from her leaking catheter. E6 stated she had been at 10:00 AM to change R10's position. R10 had no protective devices on her feet which layed directly on the mattress.

On 2/5/15 at 10:30 AM, R10 was laying on her back with wedge cushions at both elbows. Her legs were laying to the right side. She had no protection on her feet which were laying directly on the mattress. There was no padding between her legs. R10's left elbow dressing was again hanging loose and was blood/drainage soaked. The dressing was dated 2/4/14. E10, Assistant Director of Nurses/Wound cleansed the wound, applied Alginate with Santyl after applying sureprep to the wound edge. She then applied the dressing and tucked the wedge cushion under R10's arm only to have it pop back out. E10 told E17, CNA, that R10's arm needs to be off the wedge and "off loaded." E10 also stated R10 needed to have EZ boots on which were in the laundry.

As E10 did the treatments, R10's left heel ulcer did not have a dressing on and was laying directly on the bedsheet. E17 stated that R10's heel did not have a dressing on it when she turned R10 at 8:00 AM that morning. E10 cleansed the heel wound with wound cleanser then laid the heel

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001341	A. BUILDING: _____ B. WING _____	C 02/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST REHAB & RESPIRATORY	727 NORTH 17TH STREET BELLEVILLE, IL 62226

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S9999	Continued From page 11	S9999		

back on the sheet before she applied the Alginate and Santyl dressing. E10 directed E17 to inform the nurse when she notices a dressing not on a wound.

Wound documentation of R10's left heel documents that it was first identified on 12/10/14 as a deep tissue ulcer by Z1 with the plan of treatment to include skin prep and EZ boot to be worn in bed and chair to off-load wound, float heels in bed, off-load wound. Z1's weekly notes documented on 12/17/14 and 12/21/14 document no change in R10's heel ulcer. The note dated 1/14/15 and 1/21/15 identifies some improvement and on 1/28/15, no change noted. Recommendations continue to be off loading and float heels in bed. Wound documentation of the heel on 1/28/15 have measurements as 1.5 cm x 1 cm x 0.1 cm with 100% granulation, stage III, improvement noted.

TARS for January and February 2015 document only one time daily for Skin Prep to the right heel and left lateral foot ordered BID (twice daily). The Elbow treatment of the Elbow to cleanse area with wound cleanser, apply santyl and cover with a barrier dressing, change daily and PRN is only documented daily. The TAR also includes a directive to check left elbow dressing every shift but is documented only twice daily. The left heel ulcer's treatment to cleanse with wound cleanser, apply hydrogel with a 4 x 4 dressing daily and PRN is documented daily with no PRN's initialed.

On 2/11/15 at 10:15 AM, Z1 Wound Physician stated that R10's pressure ulcers on her heel and elbow were developed prior to her admission to the facility last fall.

3. The MDS dated 11/13/14 identifies R8 as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001341	A. BUILDING: _____ B. WING _____	C 02/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST REHAB & RESPIRATORY	727 NORTH 17TH STREET BELLEVILLE, IL 62226

(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
S9999	Continued From page 12	S9999		

being a 61 year old female readmitted to the facility on 11/4/14 with diagnoses of Acute Respiratory Failure, Diabetes, Chronic Obstructive Airway, and Hypertension among others.

The MDS documents R8 to be totally dependent on staff for all activities of daily living (ADL) and interviewable with Spanish being her primary language. The MDS also indicates she has a tracheostomy, gastrostomy, and urinary catheter. The care plan of 11/14/14 identifies R8's bowel incontinence and immobility as a risk factor in skin breakdown with the goal for R8 to be free from skin breakdown. Interventions include incontinent check every 2 hours and as required, wash, rinse, and dry, monitor and document intake and output per facility policy, and encourage her to use a bedpan for bowel movements and offer pan every two hours. The plan does not include turning/repositioning.

According to the Nurse's Notes, R8 was transfered to the emergency room late on 1/29/15 and returned to the facility on 2/3/15. R8's TAR's, Nurse's Notes, Weekly Pressure Ulcer reports all fail to identify any pressure ulcers on R8 upon discharge to the hospital on 1/29/15. However, hospital history and physical notes dated 2/3/15 document R8 to have "pressure sores on her back and buttock areas" with the Skin/Wound Assessment dated 1/29/15 "sacrum, gluteals, and coccyx are red, blanchable, and intact." There is no evidence the facility was aware of these areas prior to R8's discharge.

On 2/4/15 at 8:45 AM , R8 was in bed with the head of the bed elevated as she ate breakfast unattended. At 9:10 AM, 9:45 AM, 10:00 AM, 10:30 AM, 11:00 AM, 11:30 AM and11:45 AM to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001341	A. BUILDING: _____ B. WING _____	C 02/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST REHAB & RESPIRATORY	727 NORTH 17TH STREET BELLEVILLE, IL 62226

(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
S9999	Continued From page 13	S9999		

be sitting in the same position in bed with the head of the bed elevated. At 12:00 PM, R8's skin was observed with E10 and Z1. R8 had no redness or open areas on her coccyx and/or buttocks but was deeply creased. There were 3 incontinent pads under R8 along with a quarter folded bath blanket. Her heels were laying directly on the pads on the bed. E11, CNA, stated she last repositioned R8 right after breakfast when giving her the bedpan. R8 remained on her back with the head of the bed elevated through lunch and at 1:00 PM, 1:30 PM , 2:00 PM, 2:30 PM, and 3:00 PM.

On 2/10/15 at 4:32 PM, E20 LPN stated she discharged R8 to the hospital the evening of 1/29/15. E20 stated R8 was able to shift her weight side to side with assistance and did not have any open areas on the coccyx or buttocks that she knew of.

On 2/11/15 at 11:10 AM, R8 was interviewed with the assistance of E24, Respiratory Therapist, due to R8 only being speaking spanish. R8 stated she did have a sore on her coccyx and buttocks at the facility before her discharge to the hospital which the nurses were aware of but not treating. R8 stated the sores healed in the hospital before she returned to the facility.

4. R7's MDS, dated 1-5-2015, documented diagnoses, in part, Respiratory Failure, Anoxic Brain Damage and Diabetes Mellitus and total dependence of two plus persons physical assistance with mobility, transfer and hygiene.

R7's Nursing Note, dated 1-6-2015, documented, in part, "Also noted pressure ulcers on buttocks."

R7's Treatment Record, dated 1-2015,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001341	A. BUILDING: _____ B. WING _____	C 02/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST REHAB & RESPIRATORY	727 NORTH 17TH STREET BELLEVILLE, IL 62226

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S9999	Continued From page 14	S9999		

documented her treatment as "cleanse areas to coccyx with w/c (wound cleaner) apply hydrogel cover with dry dressing" which was documented as administered on 1-6-2015 and 1-8-2015 through 1-24-2015. R7's Treatment Record also documented on 1-9-2015, "area to coccyx dressed as ordered"; and on 1-16-2015, "area to coccyx has treatment in progress as ordered."

R7's Treatment Record, dated 1/2015, and her Nursing Notes, dated 1-6-2015 to 1-25-2015, and her Care Plan, dated 1-2015, did not document her pressure sore measurements, to include decline or improvement, location, effectiveness of her pressure sore treatments or pressure sore prevention measures.

R7's Nursing Notes, dated 1-25-2015, documented, in part, that R7 was sent to a local emergency room to evaluate her gastronomy tube displacement.

R7's Comprehensive Admission Skin Assessment, dated 1-31-2015, documented that she returned to the facility with "Area to coccyx measures 11 cm (cubic meter) from East to West. The right buttocks measures 5 cm from North to South, left buttocks areas measures 7 cm from North to South."

R7's Skin Issue Notification Tool to Treatment Nurse, dated 1-31-2015, documented, "pressure ulcer, blackened area, coccyx area, treatment in progress (see treatment book), blackened heels treatment in place,"

R7's Care Plan, admission dated 1-31-2015, did not document that R7 had pressure sores to include goals and interventions. R7's Treatment Record, dated 1-2015, did not document her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001341	A. BUILDING: _____ B. WING _____	C 02/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST REHAB & RESPIRATORY	727 NORTH 17TH STREET BELLEVILLE, IL 62226

(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
S9999	Continued From page 15	S9999		

pressure sore measurements, to include decline or improvement, location, effectiveness of pressure sore treatment or pressure sore prevention measures.

Interview of E10, Assistant Director of Nursing (ADON), on 2-6-2015 at 2:00p.m., E10 stated that she could not find R7's pressure sore measurements, care planning, monitoring, assessments or pressure sore preventive interventions, other than what is documented in this narrative, for any of R7's pressure sore areas.

The facility's Decubitus Care/Pressure Area Policy, reviewed January 2014, documents "4) Documentation of the pressure area must occur upon identification and at least once each week. The assessment may include: i) Characteristic (i.e. size, shape, depth, color, presence of granulation tissue, necrotic tissue, etc.); ii) Treatment and response to treatment.

(A)

300.610a)
300.690a)
300.1210b)
300.1210d)6)
300.1230b)
300.3240a)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001341	A. BUILDING: _____ B. WING _____	C 02/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST REHAB & RESPIRATORY	727 NORTH 17TH STREET BELLEVILLE, IL 62226

(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
S9999	Continued From page 16 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 Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. 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 nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents Section 300.1230 Direct Care Staffing	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001341	A. BUILDING: _____ B. WING _____	C 02/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST REHAB & RESPIRATORY	727 NORTH 17TH STREET BELLEVILLE, IL 62226

(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
S9999	Continued From page 17	S9999		

b) The number of staff who provide direct care who are needed at any time in the facility shall be based on the needs of the residents, and shall be determined by figuring the number of hours of direct care each resident needs on each shift of the day.
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 record review and interview, the facility failed to follow their policy
for use of mechanical lifts and 2 person transfers, and failed to ensure safety measures and proper transfer techniques were used during a mechanical lift transfer for 1 of 6 residents (R9) reviewed for safe transfers in the sample of 13. This failure resulted in R9's being improperly lifted and transferred, causing him to have his tracheotomy tube dislodged from his throat, suffer respiratory distress, become unresponsive and need emergency intubation and hospitalization. R9 is currently admitted to a local hospital and continues to be unresponsive.

Findings include:

1. R9's Minimum Data Set (MDS), dated 12/5/2014, documented diagnoses, in part, of Multiple Sclerosis, Nasogastric Feeding Tube, Tracheostomy and Ventilator Dependant. The MDS documented R9 has total dependence of two plus persons for physical assistance, mobility and transfer needs. R9 is assessed with having

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001341	A. BUILDING: _____ B. WING _____	C 02/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST REHAB & RESPIRATORY	727 NORTH 17TH STREET BELLEVILLE, IL 62226

(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
S9999	Continued From page 18	S9999		

bilateral upper and lower extremity limitations in range of motion.

R9's Nursing Note, dated 2/4/2015 at 2035 (8:35 PM), documented, in part, "Resident became anoxic when care was being given. CNA (E13, Certified Nursing Assistant) reported to respiratory that he had lost his tracheostomy tube at time of transfer." It was also documented that R9 was sent to a local emergency room and admitted to a local hospital with respiratory distress.

On 2/5/15 at 9:30 AM, E2, Director of Nursing (DON), stated she had not been informed of the incident with R9 until this morning (2/5/15) when she arrived at work. E2, began to investigate the incident at around 7:45 AM, that E13 had lifted R9 by herself and caused R9's tracheostomy tube to be dislodged and was sent to the hospital. E2 stated E10, ADON was on call last night (2/4/15), and should have been called by staff, and an incident report started.

On 2/5/15 at 10:00 AM, E10, ADON, stated "No staff had called her and she knew nothing about R9's being sent to the hospital last night."

The Facility Incident/Accident Report dated 2/4/15, written by E15, Licensed Practical Nurse, documented "Went down to resident's room where he was being bagged (manually ventilated with Ambu bag) by RT (respiratory therapist) and another RT assisting trying to replace dislodged trach. (Z3, Physician) at bedside assisting and she and RT was able to replace trach. Resident was still cyanotic, bagging continued until he was placed back on Vent. O2 sats began to improve. Residents color returned to normal. Physician gave orders to transfer resident to ER for further

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001341	A. BUILDING: _____ B. WING _____	C 02/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST REHAB & RESPIRATORY	727 NORTH 17TH STREET BELLEVILLE, IL 62226

(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
S9999	Continued From page 19 assist." R9's Hospitalist History and Physical, dated 2/4/2015, documents "52 YO (Year Old) with H/O (History Of) MS (Multiple Sclerosis), trach and vent dependent presented to the ED (Emergency Department) from his SNF with reported nonresponsive after trach tube dislodged. Pt (Patient) unresponsive at this time." The History and Physical documented "SNF (Skilled Nursing Facility reported that pt was found non responsive and his trach tube dislodged-replaced at SNF per staff - remained nonresponsive and sent for evaluation. Reportedly when found noted with O2 sats in the 40's - SNF stated that at baseline pt is A/O (Alert and Oriented) x 3." On 2/5/15 at 8:30 AM, E2 in her investigative notes on 2/5/15 at 8:30 AM, documented: "Call to (Employee).... looking for incident report. Not aware of one, not in building when it occurred. 2/5/15 - 9:00 AM, (E15), called 2nd time, no incident report made. Was not in room with resident, will come in to make out report. 2/5/15 - 2:30 PM, Called (E13) back. Admitted did transfer by herself." On 2/5/2015 at 11:55 AM, E1, Administrator, stated "It was the Facility's policy to use two person assistance when using the mechanical lifting device." E1, stated no incident report had been made regarding R9's dislodged trach tube. On 2/5/2015 at 11:10 AM, E13, Certified Nurses Aide, CNA, stated, "Last night, 2/4/2015, I put him (R9) from chair to bed. Yes, I did it by myself. He uses a (mechanical) lift . We are supposed to use 2 people when using the (mechanical) lift but last night we didn't have enough staff, so I used the (mechanical) lift by myself. His machine	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001341	A. BUILDING: _____ B. WING _____	C 02/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST REHAB & RESPIRATORY	727 NORTH 17TH STREET BELLEVILLE, IL 62226

(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
S9999	Continued From page 20	S9999		

beeped so I got (E18, Respiratory Therapist). Yes, when the machine beeps it means a problem with his breathing and he did seem to have some problem breathing."

On 2/5/2015 at 1:30 PM, Z4, Sitter for R9, stated that she was not present at time of R9's dislodged tracheostomy but "many times they (staff not identified) have transferred him by themselves (one staff only)." Z4 also stated R9 can only move his head and could not have pulled out his tracheostomy.

On 2/5/2015 at 1:35 PM, R2 stated that she witnessed E13 transfer R9, by herself (only one staff), with a mechanical lift from chair to bed. R2 stated she witnessed R9's tracheostomy tube pulled out during the transfer after which E13 placed R9 on his back in his bed, with the mechanical lift sling under him, and left the room to get assistance. R2 stated R9's tracheostomy stoma was bleeding excessively, and there was blood all over the place, while he laid in bed.

On 2/5/15 at 2:00 PM, in an additional interview with E 1 she stated "There are usually 3 CNA's assigned to the 300 hall, and 3 CNA's assigned to the 400 hall (6 total) on the evening shift. On 2/4/15 for the evening shift, only 4 CNA's had reported for duty and 1 CNA went home early. This left only 3 CNA's to cover both the 300 and 400 halls instead of the6 usually scheduled on that side of the building."

On 2/6/2015 at 2:20 PM, E18, Respiratory Therapist, stated on 2-4-2015 at 2025 (8:25 PM), E13, CNA, informed her that R9's machine was alarming. E18 stated that she entered R9's room and found him laying in bed with his tracheostomy out / dislodged, and a lot of blood at his stoma

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001341	A. BUILDING: _____ B. WING _____	C 02/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST REHAB & RESPIRATORY	727 NORTH 17TH STREET BELLEVILLE, IL 62226

(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
S9999	Continued From page 21	S9999		

site. E18 stated R9 became cyanotic after which an staff began to ambu bag R9. R9's tracheostomy was re-inserted. E18 stated that "Prior to this event, R9's tracheostomy was securely attached with a collar and that his tracheostomy could not fall out from being rolled side to side and that it would have to be pulled out.".

The Facility's "Lifting Machine, Using a Portable", policy and procedure, revised April 2007, documented, "The portable lift can be used by one nursing assistant if the resident can participate in the lifting procedures. If not, two (2) nursing assistants will be required to perform the procedure."

On 2/5/2015 at 10:45 AM, E3, Licensed Practical Nurse, LPN, stated that R9 required two person assistance with the mechanical lift, that he could lift only his head and was totally dependent for all other movement.

On 2/5/2015 at 1:00 PM, E19, Restorative Aide, stated that R9 was not able to move his arms.

On 2/6/2015 at 2:20 PM, E18, stated R9 was not able to to move is hands to pull out his tracheostomy and that he was not having a seizure at that time his tracheostomy tube became dislodged from it's site.

On 2/13/15 at 10:00 AM, in a phone interview, E1 stated the above incident report written by E15 was not written on 2/4/15 as documented, but written on 2/5/15. E1 stated that the report documents 2 CNA's assisted R9 on 2/4/15 when his tracheostomy became dislodged, however this is an error, there was only 1 CNA who transferred R9 at the time of the event on 2/4/15.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001341	A. BUILDING: _____ B. WING _____	C 02/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST REHAB & RESPIRATORY	727 NORTH 17TH STREET BELLEVILLE, IL 62226

(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
S9999	Continued From page 22	S9999		

(A)

TAG NUMBER: F-314 **SCOPE:**

1. ***Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?***

R5 no longer resides in the facility.
R7 was assessed and no negative outcome noted. Care plan was reviewed and updated accordingly
R8 was assessed and no negative outcome noted.
R10 was assessed and no negative outcome noted. Care plan was reviewed and updated accordingly

2. ***How will you identify other residents having the potential to be affected by the same deficient practice?***

All residents have the potential to be affected by the alleged deficient practice.

3. ***What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?***

Facility has performed education with nursing staff on the Pressure Ulcer Policy and Prevention Procedure, including identifying, assessing, monitoring and treating any resident at risk for pressure ulcers.
Facility has performed education with the licensed nursing staff on proper Transcription of Physician's orders to the Treatment Administration Record.
Facility has performed education with the licensed nursing staff on completion of Treatments.
Facility has performed education with the licensed nursing staff on Physician notification of pressure ulcers have declined.
Facility has performed education to CNA's on notifying the nurse if a dressing is loose or not in place.
Facility has performed education to CNA's on reporting all skin changes to the nurse as well as pressure ulcer prevention.
Braden scale has been updated on all residents with plan of care reviewed and updated accordingly
DON/Designee will perform random reviews of admissions and readmission records to assure all skin impairments are addressed and appropriate treatment orders are obtained, placed on TAR and care planned.
DON/Designee will perform random reviews of the TAR to assure compliance.
DON/Designee will perform random observations to assure dressings are in place to assure compliance.
Facility has reviewed the Pressure Ulcer Policy and Procedures and updated accordingly.

Facility has performed a Facility wide Skin assessment of all residents who reside in the facility.
Resident's skin will be assessed upon Admission, Readmission, as needed, Quarterly and Significant Change.
Facility has performed education with nursing staff on the Pressure Ulcer Policy and Prevention Procedure, including identifying, assessing, monitoring and treating any resident at risk for pressure ulcers.
Facility has performed education with the licensed nursing staff on proper Transcription of Physician's orders to the Treatment Administration Record.
Facility has performed education with the licensed nursing staff on completion of Treatments.
Facility has performed education with the licensed nursing staff on Physician notification of pressure ulcers have declined.

4. ***How will you monitor the corrective action(s) to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?***

DON/ Designee will perform random reviews of admissions and re-admissions 3 times a week for 8 weeks then weekly for 4 weeks to assure all skin impairments are addressed and appropriate treatment orders are obtained, placed on TAR and care planned.
DON/Designee will perform random reviews of the TAR 3 times a week for 8 weeks and then weekly times 4 weeks to assure compliance.
DON/Designee will perform random observations of dressings to assure compliance 3 times a week for 8 weeks then weekly times 4 weeks.
DON/Designee will perform random observations of Residents at risk for Pressure Ulcers 4 times a week for 8 weeks, then weekly times 4 weeks to assure appropriate identification, assessment, monitoring and treatment.
Resident's skin will be assessed upon Admission, Readmission, as needed, Quarterly and Significant Change.
Results of these reviews will be reviewed in the Quarterly QA meeting times 3 quarters with educational needs discussed.

COMPLETION DATE: 2/17/2015 Accepted

Attachment B
Imposed Plan of Correction

TAG NUMBER: F-323 **SCOPE:**

1. ***Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?***

   R9 is not currently in the facility.

2. ***How will you identify other residents having the potential to be affected by the same deficient practice?***

   All residents that require assist with transfers have the potential to be affected by the alleged deficient practice.

3. ***What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?***

   E13 Received 1:1 in-service training on the policy and procedures for mechanical lift transfers and all assisted transfers.
   Nursing staff and respiratory therapists were in-serviced on the policy and procedures for mechanical lift transfers and for all transfers.
   Facility has reviewed the Transfer Policy and Procedure and updated accordingly.
   Facility has reviewed the Transfer Policy and Procedure for Mechanical Lifts and updated accordingly.
   Facility has performed education with nursing staff that any resident utilizing a Hoyer lift for transfers must be done with 2 staff members.
   The IDT Team has identified all residents that require a Hoyer lift for transfers.
   All residents has been assessed for transfer needs with Plan of Care updated accordingly
   Resident transfer status will be assessed upon Admission, Readmission, as needed, Quarterly and Significant Change.

4. ***How will you monitor the corrective action(s) to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?***

   DON/ Designee will perform random observations of transfers 3x per week for 8 weeks then weekly for 4 weeks to insure proper transfer technique is used.
   Results of the reviews will be discussed with the interdisciplinary team 3 times per week for 8 weeks then weekly for 4 weeks to insure resident safety is maintained.
   Ongoing compliance will be discussed in the quarterly QA meeting for 3 quarters, with educational needs discussed.

COMPLETION DATE: 2/17/2015 accepted

Attachment B
Imposed Plan of Correction