STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145631	A. BUILDING _____ B. WING _____	**09/29/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NEWMAN REHAB & HEALTH CARE CTR	**418 SOUTH MEMORIAL PARK DRIVE NEWMAN, IL 61942**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to safely transfer one resident (R1) using a sling type mechanical lift. This failure resulted in a fall causing a hematoma on R1's head. Three residents were reviewed for falls in a sample list of three residents. Finding include: R1's Fall Risk assessment dated [DATE] documents R1 is at high risk for falls. This assessment documents R1 uses a sling lift and a wheel chair, had a previous fracture, and has Dementia. R1's Care Plan includes a problem initiated 10/12/18 documenting risk factors that require monitoring and intervention to reduce potential for self injury. This problem is documented as last revised 1/10/19. There is no documentation of the use of a mechanical lift in R1's Care Plan. R1's Minimum Data Set ((MDS) dated [DATE] documents R1 is severely cognitively impaired and totally dependent for transfer requiring two or more staff to assist with transfer. R1's Progress note dated 7/16/20 at 1:00PM documents (R1) showered this shift. When placed back in bed with (sling type mechanical lift) (R1) bumped head. No bruising noted. No redness at this time. Will monitor. R1's progress note dated 9/20/20 documents at 1:00PM (R1) was being transferred by mechanical lift to bed, resident fell from mechanical lift. Unsure what caused fall at this time. Incident to be investigated. Primary Care Physician notified. (R1) sent to emergency room for evaluation and treatment. On 9/29/20 at 11:00AM V7, family member stated, I met (R1) at the hospital. (R1) had an area on the back of her head that was swollen. It was the size of an egg. The hospital doctor called it a 'hematoma'. It was painful. On 9/28/20 at 11:40AM V8, Temporary Certified Nurse's Aide stated (TCNA) I did use a (sling type mechanical lift) to transfer (R1) on 9/20/20. I did it by myself and I should have asked for help. I used a blue sling. (R1) moved when I had her up in the lift and the strap came loose and she fell . (R1) hit her head on the legs of the lift. I did get about a month's training when I started here. I did know better than to use the (mechanical lift) alone. When asked what size the blue sling is V8 stated I'm not sure. The blue slings in the supply room are labeled as extra large. The manufacturer's guide lists an extra large sling for a weight range of 200 pounds to 450 pounds. On 9/19/20 R1's health care provider visit documents her weight as 101 pounds. On 9/28/20 at 12:00PM V1, Administrator stated (V9) Restorative Aide goes through a skills checklist for all new employees which includes use of the (sling type mechanical lift). V8 had that checklist by (V9). After R1's fall we repeated the checklist for all CNA's. (V8) should not have used the lift by herself. We would never recommend that.
F 0727 **Level of harm -** Potential for minimal harm **Residents Affected -** Many	**Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.** Based on interview and record review the facility failed to maintain at least eight consecutive hours of registered nursing coverage in a 24 hour period for one day of two months staffing reviewed for RN (Registered Nurse) coverage. The facility also does not currently have the services of a full time director of nursing. These failures have the potential to affect all residents. Findings Include: The August 2020 working schedule provided by the facility includes scheduled hours for V3 Registered Nurse (RN) and V4 Registered Nurse (RN). These nurses are documented per agency time sheets for August 2020 as agency nurses. The only additional RN is V2, Registered Nurse (RN). V3 is circled on the August schedule for August 1st, 6th, 7th which indicates that V3 did not work those days. On 9/28/20 at 10:00AM V1, Administrator stated The facility currently is without a Director of Nursing and the only registered nurse employed by the facility is (V2). (V3) and (V4) are registered nurses employed by an agency which provides nursing staff. (V3) missed August 1st, 6th, and 7th related to a personal emergency. (V2) had covered the 6th and (V6), Corporate RN had covered the 7th, (though the schedule does not reflect this). V1 stated the facility was without RN coverage August 1st. The Nurse's Midnight Census Report for 9/28/20 documents a resident census of 39 residents.

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.