STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146039	A. BUILDING ______ B. WING ______	C 11/30/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTVIEW TERRACE	**100 EASTVIEW PLACE** **SULLIVAN, IL 61951**

(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 323	Continued From page 5 A Fall Investigation Report, dated 9/14/11, documents R1 fell while being assisted by one staff member to the toilet. On 11/22/11 at 9:25 a.m., E7 (Certified Nursing Assistant) stated, the morning of 9/14/11 she was transferring R1 by herself from the toilet to the wheelchair. E7 stated R1 let go of the grab bar, lost his balance, and he fell into the tub area. On 11/23/11 at 9:20 a.m., E2 (Director of Nursing) stated R1 required the assistance of two people to transfer, when he fell on 9/14/11.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210b)5) 300.1210d)6) 300.3240a) 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. Restorative measures shall include, at a minimum, the following procedures: 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.	F9999		

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Continued From page 6

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 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These requirements are not met as evidenced by:

A. Based on interview, record review and observation the facility failed to ensure that one of six residents (R11) reviewed for falls in the sample of eleven was transferred safely with the use of a mechanical lift. Staff failed to provide stabilizing support to R11's torso during transfer, resulting in R11 falling from the lift. R11 sustained multiple rib fractures on the left side which caused flailing of the chest and thus caused R11's death.
Findings include:
R11's November 2011 Physician's Order Sheet documents R11's diagnoses as Epilepsy and Cerebral Vascular Disease with Left side Hemiplegia. R11's Annual Minimum Data Set dated 8/2/10 documents that R11 required assist of 2 with transfers with a mechanical Lift. R11 required total assist for all Activities of Daily

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F9999	Continued From page 7 Living. R11's admission nursing assessment dated 6/9/09 documents R11 is paralyzed on the left side. The Incident Log record showed on 4/27/11 an incident investigation was initiated regarding a fall from a mechanical lift that happened to R11 at 5:20pm that day. E2, Director of Nursing said on 11/23/11 at 2:00pm that E16, Certified Nurse Aide and Z3, Agency Certified Nurse Aide, were transferring R11 from her bed to the wheelchair. E2 stated R11's bed was approached with the mechanical lift from the wall side of the bed, instead of the opposite side where more space was available to maneuver the lift. According to E16, and as demonstrated by E2, the wheelchair had been put at the end of the bed so that R11 was being moved in the lift sling from the bed backwards toward the room door. Z3 was at the opposite side of the bed so the only bodily control that Z3 had was R11's legs. R11 began to slide out of the sling on the left side and fell to the floor hitting her left side on the metal leg of the lift and floor. On 11/23/11 at 10:45am, E2, Director of Nursing, said that R11 was immediately sent to the Emergency Room for evaluation and R11 returned the next day. The "Disposition from the Emergency Room," dated 11/28/11, states, "Patient presented to the ER (Emergency Room) with trauma to the left chest multiple fractures, flail chest and 70% pneumothorax, right kidney hydronephrosis and obstruction secondary to a calculi." The Emergency Room report also said no treatment was done per family's request. R11's family requested for R11 to go back to the nursing home for comfort measures and the Emergency Room Physician documented, "Prognosis poor."	F9999		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F9999	Continued From page 8 E16, Certified Nurse Aide said on 11/23/11 at 11:15am that she was in control of the mechanical lift and the reason that they did not do the transfer on the other side of the bed was because the roommate gets very upset when you get in her space. E16 said that as soon as she cleared the bed with R11 suspended in the mechanical lift sling, R11 started to slide out of the sling and Z3 was not in position to control R11's body. Failure of staff to ensure the adequate amount of space for the transfer and not having control of R11's during the transfer resulted in R11 slipping through the sling on the left side going to the floor. R11 hit her ribs on the metal base leg to the mechanical lift and the floor, causing several rib fractures and the left side which caused a flailing chest. R11 subsequently died as a result of the injuries. Z1, Physician, stated on 11/23/11 at 2:25pm that, "Yes the fall and fracturing the ribs ultimately was the cause of (R11's) death. She was fragile." (AA)	F9999		