STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145430	A. BUILDING _____ B. WING _____	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN NURSING HOME	1507 7TH STREET LINCOLN, IL 62656

(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 10 of interventions identified to prevent further falls for R4. On 2/17/12 at 9:00AM, E2/DON (Director of Nursing) verified there was no documentation to support that interventions were tried for R4 after falling on 8/6/12 and 8/30/12.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b) 300.1210b)2) 300.1210b)4) 300.1210b)5) 300.1210c) 300.1210d) 3001210d)4) Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least	F9999		

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F9999	Continued From page 11 restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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. 2) All nursing personnel shall assist and encourage residents so that a resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable. All nursing personnel shall assist and encourage residents so that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.	F9999		

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F9999	Continued From page 12 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: 4) 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. (Source: Amended at 35 Ill. Reg. 11419, effective June 29, 2011) 300.3240a) 300.3240b) 300.3240c) 300.3240d) 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) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act) c) A facility administrator who becomes aware of	F9999		

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abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. (Section 3-610 of the Act)
d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act)

Findings include:

The Facility Policy titled "Fall Prevention", indicates that a "Post fall quality assurance investigation will be completed with a summary documented" and "Care plan will be reviewed and revised as indicated."

1. A Physician's Order Sheet dated 2/01/12, indicates R6 has the diagnoses of Muscle Weakness, Dementia, and Anxiety. A Minimum Data Set dated 5/27/11, documents R6 as having functional limitation in range of motion in both lower extremities and requires a wheelchair for mobility. A Plan of Care dated 12/20/10 identifies R6 may be at risk for injury related to transferring and is at risk for falling related to a decline in physical functioning, poor sitting/standing balance, decreased muscle strength, and poor safety awareness. Physical Therapy notes dated 5/26/11, document R6 was assessed for transferring ability. A Physician's Order dated 5/26/11, indicates R6 was to "transfer (with standing lift) 2 person assist." On 5/26/11, R6's Plan of Care was updated and indicated R6 would no longer be transferred with a standard

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F9999	Continued From page 14	F9999		

mechanical lift and could be transferred with a standing mechanical lift and the assistance of one staff person.

A Fall Occurrence dated 6/03/11, documents R6 was being transferred from the wheelchair to her bed with the standing lift and the assistance of E5 (Certified Nursing Assistant) and R6 "slipped off the bed" and was "eased" to the floor. The Fall Occurrence documents the "root cause of the fall was resident lowed to the floor when being transferred to bed from wheelchair" and that the Plan of Care was updated to prevent reoccurrence. The Fall Occurrence failed to identify that R6 had been transferred with the assistance of one staff person, instead of two persons, as ordered by the Physical Therapist and Physician. The Plan of Care, developed 6/06/11, indicates R6 sustained a fall with out an injury, but does not identify any fall prevention interventions or address the proper method to use to transfer R6.

On 2/15/12 at 1:10 p.m., E4 (Care Plan Coordinator) who completed the 6/03/11 Fall Occurrence and Plan of Care, indicated E5 transferred R6 alone on 6/03/11 and that the 6/06/11 Care Plan failed to reflect any interventions to prevent falls.

A Nursing Note dated 10/28/11, documents "C.N.A. (Certified Nursing Assistant) was using (standing lift) and resident couldn't hold on and let go of arm bars. C.N.A. grabbed (R6) buttocks and held on and slid (resident) to floor. Assessment done on (R6) with no apparent injuries noted. Resident placed in bed with 4 caregivers and (R6) started to (complain) of right

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hip pain." The Fall Occurrence dated 10/28/11, failed to include an investigation into the fall or identify a root cause of the fall. A x-ray of the right hip on 10/29/11, identifies R6 sustained an "impacted fracture" of the neck of the femur. The Plan of Care, revised on 11/01/11, documents that R6 fell on10/28/11, but failed to identify any fall prevention interventions or address the proper method to use to transfer R6.

The Operations Manual for the stand lift identifies that a safety belt is attached to the sling, which is to be placed securely around the patients lower back just above the belt line.

On 2/15/12, at 2:00pm, the stand lift harness was noted to have a safety belt that could be adjusted to fit snugly around the waist of a patient.

On 2/16/12 at 10:30 a.m., E6 (Certified Nursing Assistant) stated she transferred R6 by herself with the standing lift on 10/28/11. E6 stated R6 said she "couldn't hold on" and she then lowered R6 to the ground.

On 2/16/12 at 9:20 a.m., E2 (Director of Nursing) stated for R6 to have to be lowered to the floor (during the transfer on 10/28/11) the chest strap on the harness of the standing lift was either too loose or not secured properly.

On 2/16/12 at 10:15 a.m., E7 (Physical Therapy Manager) stated the Therapy Department ensures staff are aware of how to properly use the harness on a standing lift. E7 stated, when using the standing lift "if the sling and safety strap are on correctly, and the resident lets go of the grab bars, she would be hanging in the harness

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F9999	Continued From page 16 and wouldn't fall to the floor." 2. R9's POS (Physician's Order Sheet) dated 2-12 shows R9 has an abnormal gait, Alzeimer's disease, Congestive Heart Failure and Cellulitis. R9's care plan dated 1-11-12 list the following interventions related to falls; seat alarm at all times dated initiated 1-3-12 and to make sure her seat alarm is in place and working initiated 1-23-12. On 2-15-12 at 11:20 am, R9 was up in a recliner in her room with no seat alarm on her chair. E8 (Certified Nursing Assistant/CNA) at 11:20am stated R9 did not have/use a seat alarm in her chair. At 11:25am, E8 came back and put a seat alarm on R9 chair stating she was mistaken and R9 is to have the seat alarm. On 9-28-11 at 9:05 am, R9 nursing note state R9 was found on the floor on her back. There is no fall investigation completed for this incident nor were any new interventions developed and care planned. On 12-10-11 at 11:40 pm, R9's nursing notes stated R9 fell while going to the bathroom. There is no investigation/root cause analyze into the incident or new interventions developed and care planned. On 12-31-11 at 2:41 pm, R9's nursing notes state R9 had a fall earlier in the day. No documentation of the fall could be found. There is no investigation/root cause analyze into the incident or new interventions developed and care planned to prevent further falls.	F9999		

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On 1-20-12 at 12:09 pm, facility's Post Fall Management form shows R9 was getting clothes from her closet unassisted and fell. The investigation shows R9's seat alarm battery was dead and did not alarm. The battery was replaced and a new intervention implemented stating to make sure seat alarm is on and functioning.

On 1-21-12 at 5:45 am, facility's Post Fall Management form shows R9 was "getting clothes from drawer due to soiling" and fell. The investigation shows R9 did not have her seat alarm on as per care plan instructions. A new intervention listed on the Post Fall Management form states to "offer resident toilet after shift change occurs." This intervention is not listed on R9 present plan of care.

On 2-16-12 at 2:00 pm, E2 (DON) verified there were no investigations completed for R9's falls on 9-28-11, 12-10-11 and 12-31-11. E2 also verified no new interventions were developed after these falls to add to the care plan. E2 stated the fall intervention developed after the 1-21-12 fall was not added to R9's care plan.

3. Post Fall Investigation form dated 8/6/11 for R4 documents that R4 fell while ambulating with her walker. The Post Investigation and Witness Statement form show no evidence of interventions identified to prevent further falls for R4.

Post Fall Investigation form dated 8/30/11 for R4 documents that R4 fell when attempting to sit back in her wheelchair. The Post Investigation and Witness Statement form show no evidence

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F9999	Continued From page 18 of interventions identified to prevent further falls for R4. On 2/17/12 at 9:00AM, E2/DON (Director of Nursing) verified there was no documentation to support that interventions were tried for R4 after falling on 8/6/12 and 8/30/12. (B)	F9999		