STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145269	A. BUILDING _____ B. WING _____	C 02/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPE CREEK CARE CENTER	**4343 KENNEDY DRIVE EAST MOLINE, IL 61244**

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F 323	Continued From page 5 stated that she couldn't find E22(CNA) to help, she left at 1:30PM. E8 stated that R1 is supposed to be 2:1 mechanical lift transfer, but E8 put him to bed by herself. At that time R1's eye was dark blue. E8 stated that she reported it to E21 shortly after putting R1 to bed. E8 stated as far as she knows she did not bump R1 with mechanical lift. E8 stated that she asked E9 (CNA) to say she was in the room during the transfer because she didn't want to get in trouble for transferring R1 with mechanical lift by herself. On 2/1/12 at 11:15 AM, E9 (CNA) stated that on 1/25/12, E8 called and asked E9 to say she was in the room during mechanical lift transfer of R1 because E8 didn't want the facility to know she transferred R1 alone. E9 stated that she told E8 that she was not even in the facility that day and she couldn't lie for her. On 2/1/12 at 3:30 PM, E1 stated that R1 is a 2:1 mechanical lift transfer. E1 stated that R1 did not have a black eye on 1/23/12 until 1:30 PM. E1 stated that E8 improperly transferred R1 by mechanical lift by herself. E1 stated that R1's eye would be in line with the mechanical lift arm with bar that swings if you don't have a second person to hold onto it. E1 stated that the care plan specifies to use 2:1 to transfer R1 with the mechanical lift.	F 323		
F9999	FINAL OBSERVATIONS Licensure Violations: 300.610a) 300.610c)2) 300.1210b)5)	F9999		

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F9999	Continued From page 6 300.1210c) 300.1210d)6) 300.1220b)3) 300.1220b)8) 300.1220b)9) 300.3240a)	F9999		

Section 300.610 Resident Care Policies
a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.

c) These written policies shall include, at a minimum the following provisions:

2) Resident care services including physician services, emergency services, personal care and nursing services, restorative services, activity services, pharmaceutical services, dietary services, social services, clinical records, dental services, and diagnostic service (including laboratory and x-ray).

Section 300.1210 General Requirements for

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F9999	Continued From page 7 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. 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: 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.	F9999		

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F9999	Continued From page 8 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 indicated by the resident's condition. The plan shall be reviewed at least every three months. 8) Supervising and overseeing in-service education, embracing orientation, skill training, and on-going education for all personnel and covering all aspects of resident care and programming. The educational program shall include training and practice in activities and restorative/rehabilitative nursing techniques through out-of-facility or in-facility training programs. This person may conduct these programs personally or see that they are carried out. 9) Participating in the development and implementation of resident care policies and bringing resident care problems, requiring changes in policy, to the attention of the facility's policy development group.	F9999		

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F9999	Continued From page 9 Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. This Requirement is not met as evidenced by: Based on interview and record review, the facility failed to attach all straps of the mechanical lift sling prior to transferring R2 and failed to have two staff present as specified in the care plan when transferring R1 with the mechanical lift. This involves two of four residents (R1, R2) transferred with the mechanical lift in the sample of twelve. R2 fell from the lift pad during the mechanical lift transfer sustaining a Right Clavicle and Right Orbital Fracture. R1 sustained a black eye. Findings Include: 1. R2's Quarterly Minimum Data Set dated 12/16/11 documents that R2 is alert and oriented. This same Minimum Data Set identifies R2 as totally dependent on staff for transfers, locomotion on and off unit with wheelchair and for personal hygiene including bathing. The Care Plan dated 12/21/11 documents that R2 demonstrates decreased physical mobility and requires Mechanical Lift with 2:1 assist for transfers. The Goal is that R2 will transfer with mechanical lift safely with 2:1 staff. The Approaches are: explain task to resident, Monitor for safety when (R2) is transferring with mechanical lift, 2:1 for mechanical lift transfers and calm approach.	F9999		

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The Event Report dated 9/8/11 3:55 PM, documents that R2 was observed on the floor on right side with head on the mechanical lift leg. R2 was bleeding from right side of head near right eye.

The Investigation report of 9/8/11 documents that :
Resident was being transferred with mechanical lift and two staff assist. Staff did not use the side straps of the sling because of not being used. Resident fell side ways out of the sling to the floor landing on the mechanical lift legs causing a laceration to right eye. The investigation report was faxed to IDPH on 9/9/11.

The nurses notes dated 9/8/11 at 10:00 PM document that R2 was sent to hospital in Peoria and returned on 9/9/11 at 10:00 PM.

The hospital History and Physical dated 9/8/11 under Assessment and Plan documents that R2 sustained right orbital fracture and facial fractures with exophthalmia and concern for entrapment of the Extra Ocular Movements. Imaging and physical examination revealed a distal clavicle fracture. R2's "clavicle fracture may require future surgical repair, but only after her facial/ophthalmologic injuries have healed. Follow up appointments: Future orthopedic consult for clavicle fracture and plastic surgery consult for facial repair after facial/orbital lesions significantly improve."

On 2/1/12 at 3:05 PM, E14/Certified Nurse Aide stated that he was told not to use the middle strap because R2 complains that it is too tight. E14

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stated that he did not know where to hook the middle straps. Most lift pads have four straps two at the top and two at the bottom. R2 had two straps in the middle, one on each side. E14 stated that CNA training only taught the basic mechanical lift transfers. "It did not train us on all types of lift pads." E14 stated that when E15/Certified Nurse Aide mechanically lifted R2 "in the air and pulled her out of bed, I was getting in position to help pull her over to the chair, (R2) fell out of the sling hitting her head on the bottom bar of the mechanical lift."

On 2/1/12 at 3:30 PM, E15 stated that she and E14 were using the full body lift pad with the mechanical lift and "did not know where to hook the middle straps to the lift, so they left them off." E15 stated that when she lifted R2 up to put her in the chair, before E14 could get a hold of R2, R2 fell out of the lift pad and onto the floor hitting her head on the bottom of the lift.

On 2/1/12 at 10:00 AM, E1/Administrator stated that E14 and E15 did not transfer R2 according to the plan of care and using the mechanical lift sling properly.

2. R1's quarterly Minimum Data Set dated 12/2/11 documents that R1 is severely cognitively impaired. This Minimum Data Set notes that R1 requires extensive assist with bed mobility, transfers, locomotion on and off the unit with a wheelchair, dressing, eating and personal hygiene.

R1's care plan dated 12/9/11 documents that R1 requires staff assist for his Activities of Daily Living, R1 can become combative with cares.

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The approach documents for staff to complete Activities of Daily Living. If combative leave and reapproach. The Problem: Behavior documents that R1 has severe Dementia. As a result he doesn't understand when staff in-forms of cares being performed. He then reacts to his reality. The Goal is to redirect from grabbing staff inappropriately. The Approach: Use two staff if able with cares, talk to R1 in a calm voice for redirection, identify behavioral triggers and 1 to 1 assist when needed. The problem Fall: documents that R1 requires 2:1 mechanical lift assist for transfers. He becomes anxious at times grabbing at staff, resident is propelled per staff or wife. R1 has a chair/bed alarm in place. One of the approaches is: 2 to 1 staff for mechanical lift transfer.

The Event Report dated 1/23/12 2:30 PM documents that R1 was put to bed with mechanical lift. R1 has a black lift eye, puffy under eye and black and blue, slight abrasion on side of left eye.

On the Investigation Report dated 1/24/12 at 10:00 AM, E21(Licensed Practical Nurse) documents that at lunch when E20 (Certified Nurse Aide) fed him, there was no red area or puffiness under left eye. E21 stated that E8 (Certified Nurse Aide) put R1 to bed about a half hour after lunch and reported to E21 that she thinks R1 is getting a black eye.

On 1/24/12, E22(Licensed Practical Nurse) stated that on the morning of 1/23/12 R1 was not cooperating in the shower room. R1 grabbed E23's(Certified Nurse Assistant) left arm. E23 put light on and came to get E22. E22 stated that

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she went into shower room and told E23 to give a bed bath if R1 wouldn't cooperate. E22 stated that R1 did not have any injuries to his left eye at that time.

On 1/25/12, E23 stated that R1 was combative and falling out of chair in shower room with her and agency CNA. E23 stated that she did not see him get any injury. E23 stated that when she left at 1:30, R1 was sitting in the recliner chair in the hallway and he had no injury to his face. E23 stated that she asked E8 (CNA) if she wanted help with R1 and E8 said no that she could get him. E23 stated that R1 had no injury from 5:00 AM to 1:30 PM when she left.

On 2/1/12 at 10:30 AM, E8 (CNA) stated that on 1/23/12, she was in a meeting all morning. E8 stated that she got to the floor around 1:00 PM. R1 was seated outside another resident's room which was not normal. R1's wife always leaves R1 outside his room after lunch. E8 stated that she pushed recliner into R1's room and saw that he had a black eye. E8 stated that she tried to find E21(LPN) to report it to her, but couldn't. E8 stated that she couldn't find E22(CNA) to help, she left at 1:30PM. E8 stated that R1 is supposed to be 2:1 mechanical lift transfer, but E8 put him to bed by herself. At that time R1's eye was dark blue. E8 stated that she reported it to E21 shortly after putting R1 to bed. E8 stated as far as she knows she did not bump R1 with mechanical lift. E8 stated that she asked E9 (CNA) to say she was in the room during the transfer because she didn't want to get in trouble for transferring R1 with mechanical lift by herself.

On 2/1/12 at 11:15 AM, E9 (CNA) stated that on

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F9999	Continued From page 14 1/25/12, E8 called and asked E9 to say she was in the room during mechanical lift transfer of R1 because E8 didn't want the facility to know she transferred R1 alone. E9 stated that she told E8 that she was not even in the facility that day and she couldn't lie for her. On 2/1/12 at 3:30 PM, E1 stated that R1 is a 2:1 mechanical lift transfer. E1 stated that R1 did not have a black eye on 1/23/12 until 1:30 PM. E1 stated that E8 improperly transferred R1 by mechanical lift by herself. E1 stated that R1's eye would be in line with the mechanical lift arm with bar that swings if you don't have a second person to hold onto it. E1 stated that the care plan specifies to use 2:1 to transfer R1 with the mechanical lift. (B)	F9999		