STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146093	A. BUILDING _____ B. WING _____	C 04/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWBROOK MANOR - LAGRANGE	**339 9TH AVENUE LA GRANGE, IL 60525**

(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 3 Facility was unable to present evidence that they have been checking the sling prior to the incident. Facility started logging it in (sling check), after the incident happened. Based on the above, the facility failed to effectively assess the sling that was used on R2. The sling broke, causing R2 to fall and sustained left broken ribs. Further observations were made regarding transfers. On 2/16/12 at 12:15 PM, R1 was transferred via sit to stand mechanical lift from chair to bed. E13 and E14 rendered incontinent care while R1 was in the the sit to stand. R1 was observed hanging precariously, clutching tightly on to the metal handle of the sit to stand lift, with no support from her lower extremities. E13 and E14 stated they can do incontinent care while resident was in the sit to stand. On 2/16/12 at 2:17 PM, E1 stated, sit to stand is being used for residents who can bear their own weight. Staff can do incontinent care while resident is standing in the sit to stand lift. The facility also failed to properly assessed R1's strength and mobility to the lower extremities which could have potentially caused harm to R1.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.1210b)5) 300.1210d)6) 300.3240a)	F9999		

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F9999	Continued From page 4 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. 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.	F9999		

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F9999	Continued From page 5 These regulations are not met as evidenced by the following: Based on observations, interviews and record reviews, the facility failed to effectively assess the strength of the mechanical lift sling used for transferring 1 resident (R2) from a sample of 3 who were observed for mechanical lift transfers. This failure resulted in R2 falling and sustained left rib fracture. Findings include On 12/13/11 at 10 AM, R2 had an appointment with the dentist. R2 was being transferred from his bed to a cardiac chair via mechanical lift by E5(CNA) and E8(CNA), when one of the upper straps of the full body sling in the mechanical lift snapped/ broke. R2 slid off from the sling and fell onto the floor. R2 was evaluated. Physician and R2's family notified of incident. R2 was sent to the hospital. At 2:00 PM the same day, R2 returned to the facility. Alert and oriented complaining of pain in his left side. R2 was diagnosed with a left fractured rib. On 12/14/11 at 9:00 AM R2 was sent back to the hospital for Hematuria (presence blood in the urine). On 2/16/12 at 3:00 PM, R2 stated, he was on a mechanical lift being transferred to a cardiac chair when the strap of the sling in his left arm broke. R2 fell all the way down to the floor at the foot of the mechanical lift. There were 2 staff (E5 and E8) with R2 at the time of incident. R2 added he couldn't breath and staff rolled him in his right side. Facility called 911 right away. R2 was told by the hospital staff that he has a broken rib cage and the hospital can't do anything about it. R2	F9999		

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F9999	Continued From page 6	F9999		

added, he wondered if facility had used the right sling on him.

On 2/16/12 at 2:17 PM, E1 (Director of Nursing) stated, facility usually had the laundry staff to check on the slings before placing it on the unit for used. E1 added facility follows manufacturer's recommendation for individual size, weight and color coding of the sling to use.

E2 presented a copy of the manufacturer's recommendation that indicated the following:

Weight	Sling Size
Strap Color	
0-100 lbs.	Small
Black	
100-200 lbs.	Medium
Blue	
210-310 lbs.	Large
Yellow	
310-450 lbs	X- Large
White	
450-1000 lbs	Bariatric
Purple	

On 2/17/12 at 3:15 PM, E11 (Laundry Aid) stated, laundry staff checked the sling after they washed it. They also give it to E1 to check. E11 added they make sure it's not broken, that there's no tear and it could hold well.

On 4/6/12 at 12:40 PM, E5 stated, that particular day E5 was just assisting E8 for transferring R2. E8 brought the sling to the room. E5 stated, he inspected the sling and did not see anything unusual with it. E5 added staff determine what sling to use through resident's care card. E3

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F9999	Continued From page 7 (Restorative Nurse Director) usually assessed the residents and decides what type of sling or harness is to be used for individual resident. E5 added , he determined the effectiveness of the sling through its wear and tear, and by rip and sheer. On 4/6/12 at 5:45 PM, E8 stated, she determined what type of sling to use for a resident through the resident's care card. E8 confirmed she checked the sling before she used it to R2 . E8 added she determined the sling's effectivity if she doesn't see any tear, holes, or rips in the sling. R2 was about 390-391 lbs at the time of the incident. The white strap sling was used on him,however, it was observed that the sling used for R2, was already very worn and thin. Facility was unable to present evidence that they have been checking the sling prior to the incident. Facility started logging it in (sling check), after the incident happened. Based on the above, the facility failed to effectively assess the sling that was used on R2. The sling broke, causing R2 to fall and sustained left broken ribs. B	F9999		