STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145711	A. BUILDING _____ B. WING _____	07/03/2012

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F 334	Continued From page 13 The facility policy titled, "Flu and Pneumococcal Vaccination" October 2005 instructs, "9. Document in the medical record including but not limited to; that the resident received an influenza or pneumococcal immunization, or immunization was medically contraindicated, or immunization was refused (Immunization Record)."	F 334		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1210b) 300.3240a) 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. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care	F9999		

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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.

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)

THESE REQUIREMENTS WERE NOT MET AS EVIDENCED BY:

Based on observation, record reviews and interview the facility failed to safely transfer a resident using the appropriate transfer device and appropriate staff assistance. The facility also failed to ensure resident safety during physical therapy.

This applies to 2 of 14 residents (R16 & R17) reviewed for falls in the sample of 24, and 1 resident (R25) in the supplemental sample.

These failures resulted in R16 sustaining an acute left humerus fracture after the staff inappropriately transferred the resident and R17 sustaining a subdural hematoma and frontal laceration after an attempt by the staff to transfer the resident.

Findings include:

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1. R16 has multiple diagnoses which include CVA (cerebrovascular accident), Dementia, muscle weakness and right AKA (above knee amputation). R16's quarterly MDS (minimum data set) dated March 26, 2012 was coded to reflect the resident has orientation and recall problems and requires extensive 2-person physical assistance during transfers. R16's transfer status form dated 3/1/10 indicates the resident requires the use of the sit to stand lift for transfers. R16's Care Giver Alert form (undated) indicates R16 requires 2-person assist with transfer, using the sit to stand lift.

On 6/27/12 at 12:10 PM, R16 was inside the second floor dining room, sitting in her wheelchair, with right above knee amputation. R16 was having difficulty expressing herself.

The final written narrative incident report dated 5/9/12 reflected, "Resident on 05-04-12 at around 10:00pm was observed grimacing and crying in her bedroom by the nurse in charge." This observation of discomfort was noted post transfer to bed. The resident was expressing pain on the left arm. The resident denied having a fall or trauma prior to pain." An X-ray of the left humerus was obtained. The X-ray results indicated, "There is a fracture of the humeral neck with mild displacement. No abnormality seen in the elbow. Osteoporosis is present." The X-ray conclusion reflected an acute left humerus fracture. The same final report indicated R16 was sent to the hospital for evaluation and treatment on 5/5/12. R16 returned to the facility from the hospital the same day with a splint and a sling to the left arm. Further review of the final written narrative reflected, "Upon interviewing of the staff involved

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in the transfer, it was discovered manual transfer of one person was completed instead of the mechanical lift transfer on the resident." "It is concluded Lt (left) humeral head fx (fracture) was caused by predisposing pathological factors of osteoporosis combined with improper transferring techniques by a CNA. Resident denies any trauma or any incidents of fall that may have caused the injury."

On 6/28/12 at 10:51 AM, E2 (Director of Nursing) stated R16's left humeral fracture was caused by the inappropriate transfer of the CNA. Per E2, the 2 CNA's (E3 and E4) involved in R16's incident gave conflicting accounts of the event and both CNA's were terminated. According to E2, upon investigation E3 stated on the night of the incident on 5/4/12, the following accounts happened:
- E3 went to R16's room to help E4 transfer the resident. Upon entering R16's room, the resident was already crying in pain and was observed with the sit to stand sling applied to the resident's upper trunk.
- E4 attempted to transfer the resident by herself using the sit to stand lift but was unsuccessful because, R16 kept on sliding out of the sling.
- Without informing the nurse R16 was crying in pain, both E3 & E4 attempted to transfer the resident with the use of the sit to stand lift from the wheelchair to bed, but were unsuccessful because R16 kept sliding out of the lift sling.
- E3 then transferred R16 manually (without the use of any lift) by herself and during the entire transfer, the resident was complaining of pain.
- When R16 was already in bed, E3 & E4 still did not inform the nurse of the residents pain.
- The nurse was told of R16's complaint of pain

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F9999	Continued From page 17 two hours post transfer, when the resident did not stop crying. During the same interview E2 stated upon investigation, E4 gave a different account of the incident on 5/4/12 as follows: - She (E4) did not attempt to transfer R16 by herself. - When E3 came in R16's room, they both (E3 & E4) attempted to transfer the resident using the sit to stand lift but, was not successful because the resident was sliding out of the sling. - E3 transferred R16 by herself without the use of any lift, because there was no time. - According to E4, this caused the fracture on the resident's humerus. 2. R17 has multiple diagnoses which include Dementia, Osteoarthritis, and DJD (Degenerative joint Disease). R17's quarterly MDS dated March 21, 2012 was coded to reflect the resident is not oriented and cannot recall. R17 requires extensive two-person physical assistance during transfers and bathing. R17's fall assessment dated 3/23/12 was coded to reflect a score of "23" indicating high risk for fall. On 6/27/12 at 11:45 AM, R17 was inside the second floor dining room, sitting up in her wheelchair. R17 was alert, confused and not able to respond appropriately even to simple questions. R17's records reflected the following fall incidents: - 1/2/12 (9:30 PM), unwitnessed fall by the hallway, resident ambulated unassisted and	F9999		

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without the use of any assistive device. Resident sustained a laceration to the back right side of the lower head, measuring 2cm x 2cm.

- 2/6/12 (6:15 PM), witnessed fall. Resident was attempted to transfer herself from the wheelchair to a regular chair. Resident lost balance and fell on the floor. No injury sustained.

- 2/10/12 (2:20 AM), unwitnessed fall. Resident was observed sitting on the floor inside her bathroom. No injury sustained

R17's written narrative Incident report to the State Agency dated 3/31/12 reflected, "On 3-31-12, at around 8:00pm, CNA in charge gave the resident a shower in the shower room and was about to transfer the resident to her wheelchair. CNA placed the gait belt around the resident's waist and was reaching for the wheelchair for the resident to transfer to while holding the shower chair where the resident was. While doing so, the resident attempted to stand up from the shower chair, had a jolted quick movement that resulted the resident to fall to the floor hitting her right side of her head sustaining a lacerated wound on the right frontal side measuring 4.5 cm x 1.5 cm....Further physical assessment was done and observed a lacerated wound on the resident's right knee measuring 1.0 cm x 0.4 cm. R17 was sent to the emergency room for further evaluation and was subsequently admitted due to abnormal CT- Scan findings of, 'Small acute right frontal temporal subdural hematoma measuring maximally 4.6mm, Small area of focal subarachnoid hemorrhage right occipital lobe, small right frontal scalp hematoma.'" Additionally, the incident narrative reports "Resident is

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observed by some staff to have a behavior of some rapid sudden movements in an attempt to stand up and resident's attention is usually diverted in these instances. Resident may have had this behavior after the shower was given and while the CNA was trying to transfer her to the wheelchair which caused the fall that resulted to the injury...Conclusion: The immediate cause of the resident's injury was due to a fall witnessed by the CNA in charge who just finished rendering shower to the resident. Resident has been identified as a high risk for falls. But due to resident's behavior and unpredictable sudden jolting movements, this then caused the resident to fall on the floor sustaining the injury."

On 6/28/12 at 11:10 AM, E7 stated she was the CNA in charge of R17 when the resident fell in the shower room on 3/31/12. Per E7, R17 would often get up from the wheelchair unassisted and often would have sudden jolted, quick movements. According to E7, on 3/31/12 after giving R17 a shower, she applied a gait belt around the resident's waist to transfer the resident from the shower chair to the wheelchair. E7 said she held on to the right side of R17's gait belt with her left hand while reaching for the wheelchair, which was located to the right of the resident, with her right hand. Per E7, during the process of her reaching for the wheelchair, R17 suddenly jumped up from the shower chair, causing the shower chair to move backwards and the resident to fall. E7 stated R17's head (right side) hit the shower bar first, then the resident fell to the floor. E7 stated when R17 landed on the floor, a gush of blood was immediately noted coming from the right side of the resident's head. According to E7 that was the first time she

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F9999	Continued From page 20 showered R17 and she does not know what to expect. R17's physician progress notes in the medical record (dated 4/7/12) reflected documentation of chief complaint, "S/P (Status Post) Subdural hematoma...Pt. fell in shower 4/1/12 & suffered a closed head injury with right frontal laceration with 9 sutures." 3. On 6/25/12 at 10:45 AM, R25 was observed being provided physical therapy by E8 (Physical Therapist) in the hallway on the first floor. R25 was ambulation unsteady with her walker while E8 was pushing R25's wheelchair with her left hand and rolling a pulse oximetry machine with her right hand. A portable oxygen tank was noted on R25's wheelchair seat. E2 (Director of Nursing) was present for this observation. E2 said E8's method of ambulating R25 was unsafe. (B)	F9999		