

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

PRINTED: 01/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145441	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/31/2012
NAME OF PROVIDER OR SUPPLIER SHELBYVILLE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 1111 WEST NORTH 12TH STREET SHELBYVILLE, IL 62565		
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F 323	Continued From page 7	F 323			
F9999	<p>FINAL OBSERVATIONS</p> <p>LICENSURE VIOLATIONS</p> <p>300.1210b) 300.1210d)6) 300.3240a)</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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.</p> <p>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:</p> <p>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</p>	F9999			

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F9999	<p>Continued From page 8 and assistance to prevent accidents.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)</p> <p>These requirements were not met as evidenced by:</p> <p>Based on observation, record review and interview the facility staff failed to ensure that the mechanical lift sling was properly secured prior to lifting one (R1) of three residents reviewed, on the sample of three, who require transfers with a mechanical lift. R1 fell out of the sling during a transfer and sustained a Skull Fracture and Acute Intracranial Hemorrhage.</p> <p>The findings include:</p> <p>On 8/24/12 a facsimile was received by the Department from the facility reporting an injury to R1 which occurred on 8/23/12 at 4:30 pm. The report documented that R1 had slid out of the mechanical lift and was transferred to the Hospital with admitting diagnoses of Subdural Hematoma and Temporal Lobe Fracture. The report indicated an internal investigation was being conducted and information would be sent upon completion.</p> <p>The final investigation report dated 8/27/12 was provided by Administrator E1 on 8/27/12. The report stated "Shelbyville Manor has completed a thorough investigation of the fall involving (R1).</p>	F9999			

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F9999	<p>Continued From page 9</p> <p>The mechanical lift has been completely inspected and it has been determined that the lift did not malfunction. The sling utilized during the transfer has been inspected and no defects have been found with the sling". The report concluded "the left leg strap was not secured properly to the lift device which resulted in (R1's) right leg falling from the sling. (R1's) buttocks then slid through the sling between the torso and leg area of the sling. It has been determined that CNA (Certified Nurse Aid E5) was responsible for securing the left leg strap to the lift. (E5) was terminated 8/24/12."</p> <p>E5's signed statement dated 8/24/12 documented "...We hooked the straps to the lift. I proceeded to push the button to lift him off the bed. When he was lifted up I started to pull the lift back. I grabbed a hold of the sling to help position him into the chair and his leg fell out...I tried to prevent him from falling but I could not hold him up until (E4) could get over there to help me and I lowered him to the floor."</p> <p>CNA, E4's signed statement dated 8/24/12 documented "...(E5) started lifting him up and once all his body weight was off the bed I went around to position his chair. As I was walking (E5) was manipulating (R1) off the bed. I was standing beside the chair and (E5) was handling the lift. (R1's) leg fell..before I could get over there (R1) fell and struck his head on the chair and the floor. I left the room to locate the DON (Director of Nursing)."</p> <p>R1's August 2012 Physician's Order Report lists diagnoses including Cerebral Vascular Accident (CVA) with Hemiplegia Affecting Side (Left</p>	F9999			

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F9999	<p>Continued From page 10</p> <p>Primary), Multiple Sclerosis, Alzheimer's Disease, Dysphagia, and Osteoporosis. R1's quarterly Minimum Data Set (MDS) dated 7/03/12 identified R1 with severe cognitive impairment, total dependence in bed mobility, and transfer with assist of 2 staff. The assessment lists R1 being totally dependent with personal hygiene and had an indwelling catheter. R1 also had functional limitations in Range of Motion (ROM) for both upper and lower extremities and had unsteady balance. R1's height and weight was 65 inches, 187 pounds.</p> <p>R1's Care Plan dated 7/12/12 documented R1 was at increased risk for falls related to diagnoses of Multiple Sclerosis, CVA with Right Sided Hemiplegia, and Osteoporosis. The care plan states "Resident is immobile, he transfers via mechanical lift. He is dependent on staff for all ADL's (Activities of Daily Living), including propelling his gerichair. He is up to a (geriatric chair) for proper positioning. He does not attempt to self transfer."</p> <p>On 8/27/12 at 1:30 pm, Administrator E1 stated that R1 was still in the hospital in stable condition, was receiving IV (intravenous) antibiotics, and anti-inflammatory medication. E1 stated R1 had a Subdural Hematoma and Temporal Lobe Fracture. E1 stated that two Certified Nurse Aides (CNAs) E4 and E5 were transferring R1 from the bed to a chair and R1 fell from the lift because, E5 did not secure the left leg strap of the (mechanical lift) sling. E1 stated E5 was operating the lift and had raised (R1) up and had started moving R1 away from the bed when R1's right leg fell out because the loop was not secure and R1 came out of the lift, hitting his head on a</p>	F9999			

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F9999	<p>Continued From page 11 chair and on the floor.</p> <p>E2 (Director of Nursing) was present during the conversation (8-27-12 1:30 p.m.) and showed the surveyor the orange sling that was involved in R1's fall. The sling was a nylon mesh construction and each side of the lift sling had three sets of color coded nylon loop straps. There were straps on each side at the shoulders, mid body and leg. The straps are used to connect the sling to the hooks on each side of the spreader bar of the lift. Once the appropriate corresponding color loop (red, green or yellow) is put over the U shaped hook a locking pin comes down to close the opening to keep the loop from coming loose when there is weight in the sling. E2 brought the lift into the room and demonstrated how the sling loops are placed over the hook and a metal clip closed over the opening when weight was put on the sling. E2 provided a list of fourteen residents (including R1) who currently require use of the Mechanical Lift.</p> <p>E1 stated on 8/27/12 at 2:00 PM they tried to figure out what happened and reenacted the incident with both CNA's using the lift and sling and with Physical Therapy and Support Services staff and they could not find any mechanical problems with the lift, or sling that would allow the loop to come off the hook.</p> <p>Director of Nursing E2 stated at 1:35 pm on 8-27-12 that she went down to R1's room immediately after she was notified of R1's fall. E2 stated when she arrived R1 was laying on the floor beside the bed, his lower back was across the leg of the lift, his head was forward and his airway was compromised so they stabilized his</p>	F9999			

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F9999	<p>Continued From page 12</p> <p>head and they removed the lift legs out from under him and he started breathing better. E2 stated on 8/27/12 at 2:00 pm that E3 (Nurse) was the first nurse to respond to R1's room.</p> <p>Nurse E3 stated on 8/27/12 at 2:15 pm that she was notified by a CNA (8/23/12) that R1 had fallen and she went running back there with E2 behind her. E3 stated R1 was still hooked up to the lift with his back and legs across the metal legs of the lift. E3 stated his head was bleeding, he wasn't talking and appeared unconscious, his pupils were pinpoint. E3 stated E2 thought his airway wasn't open, so E3 applied a towel to the back of R1's head to stabilize him and he started breathing better and became more aware. They removed the lift legs from beneath him. E3 stated she stayed with R1 until the ambulance arrived. R1's Nurse's notes dated 08/23/12 4:30 pm documents the ambulance arrived and transported R1 to the hospital.</p> <p>The hospital Radiology Report dated 8/23/12 of the CT (Computerized Tomography) of the Brain documented " Acute intracranial hemorrhage is seen within both hemispheres...predominately subarachnoid in nature..Right calvarial fracture is seen extending from the right parietal calvarium down into the right temporal lobe. There is soft tissue within the auditory canal."</p> <p>The hospital Acute History and Physical report dated 8/26/12 documented R1 " sustained laceration to right side of his head. The CT did reveal a fracture in the right parietal area extending into the right temporal area. He has a subarachnoid bleed and probably a small subdural bleed, bleeding noted in the right ear.</p>	F9999			

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F9999	<p>Continued From page 13</p> <p>Soft tissue swelling around right ear noted on CT scan."</p> <p>E4 confirmed during a telephone interview on 8/27/12 at 4:30 pm that she and E5 had placed the lift sling underneath R1 (on 8/23/12) while he was in bed and they had attached the straps of the sling to the lift bar. E4 was on the right side of the bed and E5 was on the left side of the bed. E4 stated they used red loops for the shoulder and green loops for the middle and lower leg straps. E4 stated the leg straps were crossed between his legs and were threaded through each other. E4 hooked the sling straps on her side to the lift hooks and E5 attached the straps on her side. E4 stated E5 was operating the lift and raised R1 up over the bed. E4 stated as E5 was pulling R1 in the lift away from the bed, one of R1's legs came down and he slipped out of the sling. R1's head hit the bedside chair and then the floor. E4 stated it happened so fast they were not able to stop him.</p> <p>E5 confirmed during a telephone interview on 8/27/12 at 4:45 pm that she and E4 had put the sling under R1 and they had each hooked all three straps on each side to the lift hooks. E5 stated she pushed the button control and lifted R1 up with the machine off the bed and E5 started to come around the other side of the bed with the chair. E5 stated she was getting ready to spread the legs of the lift when when R1's leg started to fall and he started coming out of the sling. E5 stated she tried to stop him from falling but she couldn't hold him up. E5 stated she has previously transferred R1 a couple times before with the lift with and had no problems. E5 said she had watched the training (mechanical lift)</p>	F9999			

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F9999	<p>Continued From page 14</p> <p>video during orientation and had a week on on the job training which included use of the lift when she started work.</p> <p>The undated facility training information from the manufacturer of the mechanical lift included "Sling Warnings" which included "Improper Sling Size, improper sling attachment or improper sling and lift inspection can cause death or serious injury...Ensure all sling straps are properly attached to lift spreader bar. Visually check nuts and bolts on spreader bar and lift..Lift resident 1-2 inches over bed or chair to ensure sling is holding resident securely and properly before further lifting."</p> <p>Physical Therapy Program Director E8 stated on 8/28/12 at 1:45 pm she felt the size of the sling used was appropriate for R1's size, weight and body structure. E8 stated as long as the sling loops were placed correctly on the hooks, they shouldn't come off.</p> <p>B</p>	F9999			