

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: 14G111	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/15/2012
NAME OF PROVIDER OR SUPPLIER CLINTON MANOR LIVING CENTER-DD			STREET ADDRESS, CITY, STATE, ZIP CODE 111 EAST ILLINOIS STREET NEW BADEN, IL 62265		
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W 149	Continued From page 6	W 149			
W9999	<p>FINAL OBSERVATIONS</p> <p>LICENSURE VIOLATIONS:</p> <p>350.620a) 350.3240a)</p> <p>Section 350.620 Resident Care Policies</p> <p>a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually.</p> <p>Section 350.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) (A, B)</p> <p>These requirements were not met as evidenced by:</p> <p>Based on record review, interview and observation, the facility failed to implement their policy to prevent neglect for 1 of 1 individual (R2) when the facility did not ensure this individual's wheelchair brakes are locked for safety, when R2 was left on an incline unattended in an</p>	W9999			

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W9999	<p>Continued From page 7</p> <p>unlocked wheelchair. The unlocked wheelchair rolled off a concrete pad, tipping the wheelchair and R2 forward and to the right, which resulted in a spiral fracture to R2's right femur that required surgical intervention.</p> <p>Findings Include:</p> <p>"Desire for the Future" (facility's Individual Program Plan(IHP)/ dated 6/8/12) identifies R2 as a 32 year old individual who functions at the Severe range of Mental Retardation with additional diagnoses of Seizure Disorder, Chronic Hip Dislocation, Fused Right Sacroiliac Joint and Dandy Walker Anomaly. R2's IHP further states the following:</p> <p>Under section titled "Review of Rights Restriction" the IHP states, "R2 requires a seat belt at all times when up in her wheelchair. She may use a chest harness at times when transporting if she is having poor trunk control."</p> <p>Under the section titled "My Physical Ability" the IHP states;</p> <p>"R2 is non-ambulatory and requires the use of a wheelchair for mobility. Her wheelchair is a custom tilt-in space Quickie with elevating leg rests, enclosed foot box, custom inflatable seating system and rear anti-tippers. R2 is unable to fully reposition herself." The IHP also states, "R2 is unable to transfer herself and requires the use of an (mechanical) lift, with 2 person assistance to do so."</p> <p>Under the section titled, "My Ability to Self Direct" the IHP states;</p>	W9999			

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W9999	<p>Continued From page 8</p> <p>"She (R2) is unable to self propel her wheelchair; therefore, she must wait for staff to evacuate her in a safe and quick manner."</p> <p>"Staff ensures R2's safety at all times, when at home or in the community."</p> <p>"In the community, R2 is never left alone, and all safety precautions are followed to ensure that she remains safe on her trip."</p> <p>Under the section titled, "Program Services" the IHP states, "R2 has contractures and deformities in both lower extremities."</p> <p>Incident/ Accident Report (dated 8/5/12) states, "On 8/5/12 at 7:02 PM (at the park), R2 was being pushed to the bus by staff with another resident following staff in her wheelchair, another client from another company decide (sig/decided) to push other residents chair and got it stuck. Staff then locked down R2's chair to assist the other resident. When staff did that R2 began to roll forward. Staff caught her before she fell out of her chair. However as she was rolling forward her foot rest tipped making (sig/ making) R2 bend forward and it went over her head. R2 was sat back up and her chair put back together properly. She was then brought home to be checked by nursing." This reports also states, "R2 stated that the back of her chair flipped (sig/ flipped) over her head when it fell off." This report was written by E5/ Direct Support Person.</p> <p>Witness statement written by E6/ Direct Support Person (dated 8/7/12) states, "R5 was pushing E2, when a resident from another facility got her</p>	W9999			

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W9999	<p>Continued From page 9</p> <p>attention, the resident had the wheelchair of resident R4 caught between the cement pad and the ground, E5 turned around to look, at her and let go of R2's wheelchair at which point the wheelchair rolled forward down into a culvert, her foot box jammed into the ground, she slammed forward, her glasses flew off, and the back of her wheelchair came off." E6 also states, "I noticed after moving the wheelchair so easily, that the wheelchair was not locked."</p> <p>In review of Nursing Progress Notes (dated 8/5/12- 8/6/12) R2 returned to the facility on 8/5/12 at 7:40 PM and was assessed by nursing who called Z2/ Physician and received orders for a portable x-rays. X-rays were taken and results were received by the facility at 2:15 AM stating, "Spiral fracture to right femur." Facility called results to the physician and R2 was transferred to local community hospital at 2:39 AM per ambulance.</p> <p>Patient Report (dated 8/6/12) of x-ray to R2's right hip states, "Spiral fracture of the proximal third of the right femur."</p> <p>In an interview with E6/ Direct Support Person on 8/5/12 at 3:05 PM, E6 confirmed that when she went to assist R2 (at the park after the above incident) that R2's wheelchair brakes were not locked.</p> <p>In interviews with E1/ Administrator, E3/Assistant Director of Nursing and E4/ Licensed Practical Nurse/ Health Care Coordinator on 8/8/12 at 11:20 AM and 11:30 AM, E1 stated, "We don't know if the brakes didn't stay or if the incline contributed." E3 stated, "It could be that it</p>	W9999			

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W9999	<p>Continued From page 10</p> <p>(brakes) didn't catch. Willing to say that maybe it (brakes) didn't go all the way down." E4 stated that R2's wheelchair had been looked at a couple of months ago and everything was fine. E4 also stated, "R2 was taken to see Z3/ Neurologist recently ,who has an incline, and the brakes worked." E4 stated that R2 can not bend her legs and sits in her wheelchair with right hip up and both legs elevated utilizing foot box. When asked if R2 ever attempts to move wheelchair by using her hands to push wheels, E4 stated, "Her (R2) arms are not long enough to touch the wheels."</p> <p>In an interview with E2/ Residential Service Director on 8/8/12 at 3:20 PM, E2 stated she had talked with R2's guardian who informed her that R2 was at (hospital in St Louis) and was having surgery to her right femur as we spoke.</p> <p>Surveyor, E1/ Administrator, E2/ Residential Service Director and E3/ Assistant Director of Nursing went to the park where incident occurred on 8/8/12 at 12:45 PM. The facility brought R2's wheelchair to demonstrate what E5 reported to them. R2's wheelchair is a custom tilt-in space with elevating leg rests, enclosed foot box and rear anti-tippers. E2 demonstrated to surveyor with the use of R2's wheelchair (with brakes in unlocked position), how the wheelchair rolled off the concrete sidewalk (which has a slight decline) onto the grass into a culvert (where two black approximately 10 inch circumference drainage pipes] protrude from beneath the side walk out approximately 3 feet from the sidewalk and about 18 inches lower than the sidewalk) causing the boxed footrests to hit the ground, tipping the wheelchair forward. Surveyor sat in R2's wheelchair at the same spot identified as where</p>	W9999			

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W9999	<p>Continued From page 11</p> <p>E5 left R2,locked the brakes and shifted weight, R2's wheelchair did not roll.</p> <p>Policy and Procedure for Van Lift Safety (dated 11/20/2009) states, "Wheelchairs which are being transported are to have their breaks (sig/ brakes) properly locked before the lift is moved up or down and are not unlocked until the lift has stopped in the full up or down position." This policy also states, "Everyone riding in an agency vehicle is to be properly secured by seatbelt or proper tie down mechanisms."</p> <p>In an interview with E2/ Residential Service Director on 8/8/12 at 3:20 PM, E2 confirmed the facility could provide no further written evidence of facility's policies on when wheelchair brakes are to be utilized.</p> <p>Facility's policy, "People are Free of Abuse and Neglect" (revised 10/2011) states, "Neglect means the failure in a long term care facility to provide adequate medical or personal care or maintenance, which failure results in physical or mental injury to a resident or in the deterioration of resident's physical or mental condition."</p> <p style="text-align: center;">(B)</p>	W9999			