STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012413	A. BUILDING: _____ B. WING _____	C 01/17/2013

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Z 000	COMMENTS Incident Report Investigation of 12/25/12/IL61031 Franciscan Village is in substantial compliance with 42 CFR Part 483, Requirements for Long Term Care facilities for this survey.	Z 000		
Z9999	FINDINGS LICENSURE VIOLATION: 300.610a) 300.1210b)5) 300.1220b)3) 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 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	Z9999		

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Z9999	Continued From page 1 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. 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. 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 regulations were not met as evidenced by the following: Based on interview and record review facility failed to follow their mechanical lift policy, care	Z9999		

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Z9999	Continued From page 2	Z9999		

plan and assessment for one resident (R1) out of three residents reviewed for falls that required two people plus mechanical lift for transfer. This failure resulted in death of R1 caused by fall from a mechanical lift and cervical spine fracture.

Findings Include:

Interview with E6 (Restorative Nurse) on 1-10-13 at 3:30 PM states R1 has been assessed each quarter to need the mechanical lift plus two people for transfers from bed to wheel chair since May 2011.

Record review of restorative clinical notes dated 2-9-12, 5-2-12, 7-18-12 and 10-9-12 denotes R1 is non-ambulatory; staff uses a mechanical lift for transfers with extensive assist x 2.

Record review of R1's current care plan report denotes problems: transfers to/from bed,chair is dependent on staff. Intervention: transfer using the mechanical lift and two assists.

Record review of report of incident for R1 dated 12-25-12 denotes " During transfer with a mechanical lift, resident (R1) fell to the floor, sustained an injury with bleeding to her face. Paramedics were called but subsequently they were unable to revive resident."

Interview with E1 (Certified Nurse Aide) on 1-10-13 at 10:10 AM states on 12-25-12 R1 was screaming to get up out of the bed. E1 states she cleaned and put R1's clothes on then placed the mechanical lift pad underneath her and called E2 (Certified Nurse Aide) to help transfer R1. E1 states E2 came in the room then the pad was hooked to the mechanical lift. E1 states started to

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Z9999	Continued From page 3 pump the lever on the mechanical lift to transfer R1 to the chair when the call light went off in another resident's room and E2 left. E1 states was going to let the R1 down back onto the bed and wait for E2 to come back but R1 insisted she not to let her back down and put her in the chair. E1 states while R1 was still in the mechanical lift she turned the machine by herself away from the bed toward the chair and before she could let the mechanical lift down the piece that holds the chain came a loose and R1 hit her face on the bedside table, landed on the floor and the chair tipped over on top of her. E1 states she yelled for help and E5 (Registered Nurse) came in the room and asked what happened. E1 states told E5 what happened, E5 left the room and came back with oxygen and a pulse oxygen machine. E1 states R1 was still breathing but was not talking just moving her eyes around, wetted a towel and wiped R1's face and tried to comfort her. E1 states then the paramedics came into R1's room then she went and waited in the hallway. E1 states she was in-service that two people need to use the mechanical lift when they are going to transfer a resident but R1 was hollering to get out of the bed and went on ahead and transferred R1 without help Record review of facility's mechanical lift policy manual denotes a mechanical lift will be used to transfer a non-ambulatory/non weight bearing residents when deemed necessary by the nurse. Special instructions must have at least two staff members to safely complete transfer. Pump the mechanical lift high enough until the residents and sling are free of the bed. With one staff member supporting the resident's leg, move the lift and resident away from the bed. When away from the bed, the second staff member needs to	Z9999		

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Z9999	Continued From page 4	Z9999		

no longer support the legs and should position him/her self at the back of the chair. With the second staff member guiding the resident, open the release valve slowly to gently lower the resident into the chair.

Interview with E2 (Certified Nurse Aide) on 1-10-13 at 10:25 AM states on 12-25-12 E1 called her and she went to the doorway of R1's room and E1 asked if she could assist her in getting R1 up from the bed. E2 states before she could go into the room another resident screamed for assistance and told E1 that she would come back to help her. E2 states after she cleaned her resident went in the hallway then E5 told her to call 911 and get staff assistance. E2 states went and got the others nurses from the others floors to help and was instructed by the nurses to wait at the front door and let the ambulance in. E2 states she is familiar with the mechanical lift policy and knows to always use two people when a resident needs to be transferred with mechanical lift.

Interview with E5 (Registered Nurse) on 1-10-13 at 1:00 PM states on 12-25-12 she heard someone scream help help, ran to R1's room and opened the door and saw R1 on the floor on her back. E5 states she saw blood on floor and that R1 was bleeding from her forehead and had small laceration to her left cheek. E5 states she told E2 the CNA (certified nurse aide) to call 911. E5 states R1 was awake, breathing but not responding to any questions. E1 states she went and got oxygen and pulse oxygen machine. E1 states she attempted to take R1's vital signs but didn't get blood pressure and then the paramedics came in the room. E5 states paramedics asked for R1's DNR (do not resuscitate) status. E5 states she left the room ,

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Z9999	Continued From page 5 retrieved R1's DNR papers, gave them to the paramedics and left the room to prepare R1's transfer papers. E5 states few minutes later paramedics said R1 passed away. Record review of R1's paramedic ambulance patient care report dated 12-25-12 denotes" Notified 3:45:46 arrived at patient 3:48:25. Staff tech was in room with a pulse ox (oxygen) on the patient and told medics that patient fell out of lifting chair as she was being moved to the wheelchair. Patient (R1) was lying supine on bedroom floor with lacerations to the right side of cheek and chin. There was another laceration on the right upper forehead with moderate amount of blood next to the patient and bloody towels next to patient. Crew immediately assessed patients ABC' (airway,breathing,circulation) and looked, listened and felt for a pulse and breathing. Patient was given a sternal rub by the crew to check responsiveness. All tests came back negative. Patient had no pulse on carotid bilaterally, no rise in chest for breathing. Patient was put on monitor and staff came in with signed and valid DNR paperwork. EMS crew asked nursing staff about the condition of patient and if witnessed. Nursing tech said that she was in the room with patient moving her and talking to her. She was lifting her in the lifting chair to move her to the wheelchair. She said patient then fell into the bottom of the table, tech said and she called for help. Tech and nurse moved patient from her side to a supine position and put a nasal canula on patient and called 911. At this time the staff said that patient was moaning but not speaking complete words". Record review of R1's police department death investigation repot denotes on 12-25-12 officer was dispatched to nursing home. Officer spoke to CNA (E1) who advised the lift machine broke	Z9999		

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Z9999	Continued From page 6 while trying to remove R1 from her bed. This caused R1 to fall from the lift falling over the chair and onto the floor. Interview with Z1 (Medical Doctor) on 1-13-12 at 12:30 PM states arrived at the facility on the morning (12-25-12) of the incident but not allowed by the police in R1's room to assess R1. Z1 states from the information that she had gathered that R1 was transferred, fell and then passed away. Z1 states the fall could be attributed to the death of R1. Record review of R1's certification of death records certified on 12-26-12 denotes R1's cause of death: Cervical Spine Fracture, Fall from lift. Injury occurred from mechanical lift. Date of death 12-25-12. AA	Z9999		