

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

PRINTED: 07/09/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145200	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/14/2013
NAME OF PROVIDER OR SUPPLIER FRANKLIN GROVE LIVING AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 502 NORTH STATE STREET FRANKLIN GROVE, IL 61031		
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F 441	Continued From page 23 R26's nightstand with the soiled glove on her right hand. The Care Plan dated 9/21/12 for R26 showed, "Provide incontinence care every 1-2 hours and as needed. Barrier cream to follow incontinent care. Report any signs or symptoms of a urinary tract infection." The Nurses Notes for R26 from 1/5/13 to 3/8/13 showed R26 had loose stools. An order for a stool softener was changed to as needed on 2/14/13. On 3/6/13 R26 started having loose stools again. The facility currently has several residents on isolation for Clostridium Difficile including R6, a resident that was on 100 hall near R26, and is now on 300 hall on isolation. The facility's Policy and Procedure for Contact Precautions showed, "Red can or garbage cans with red bags for all gloves, wipes and any disposable that have come in contact with contaminated body fluids; Always wash your hands.	F 441			
F9999	FINAL OBSERVATIONS Licensure Violations: 300.610a) 300.690a) 300.1210b)5) 300.1210d)6) 300.1220b)3) 300.3240a)	F9999			

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F9999	Continued From page 24 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 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. 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	F9999			

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F9999	<p>Continued From page 25</p> <p>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:</p> <p>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.</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 and assistance to prevent accidents.</p> <p>Section 300.1220 Supervision of Nursing Services</p> <p>b) The DON shall supervise and oversee the nursing services of the facility, including:</p>	F9999			

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F9999	Continued From page 26 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) This Regulation is not met as evidenced by: Based on Interview and Record Review the facility failed to provide safety for residents during transfers. This failure resulted in R26 sustaining a large, deep laceration to her right leg that occurred during a transfer. The facility failed to provide supervision for a resident when a general diet tray was given to a resident who cannot have anything by mouth due to Dysphagia.	F9999			

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F9999	<p>Continued From page 27</p> <p>The findings include:</p> <p>1. The Incident Report dated 12/9/12 for R26 showed, "CNA's were assisting R26 into the wheelchair using the mechanical lift. When they went up to adjust the foot pedals they noticed a large laceration to R26's right lower extremity. Upon examining the right leg, unable to steri-strip due to the depth. Only complains of pain with touch. Called the physician and nursing order received to send R26 to the emergency room."</p> <p>The Nurses Note dated 12/9/12 showed, "Called to R26's room for right lower extremity bleeding and noted a laceration to the right lower extremity; R26 returned at 9:15am with 24 staples to the right lower extremity and an antibiotic order."</p> <p>The Resident Transfer Form dated 12/9/12 for R26 showed she was transferred to the emergency room for a laceration to her right lower leg.</p> <p>The hospital Discharge Instructions dated 12/9/12 for R26 showed, "Diagnosis: Leg laceration - right lateral, status post stapling; Prescriptions: Keflex, 500mg by mouth every 8 hours for 5 days."</p> <p>The Care Plan dated 9/21/12 for R26 showed, "Mechanical Lift x 2 assist for all transfers; Uses wheelchair for mobility.</p> <p>The Care Plan Review Notes dated 2/6/13 for R26 showed, "R26 is non-ambulatory and is assisted with wheelchair for locomotion."</p>	F9999			

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F9999	Continued From page 28 On 3/13/13 at 9:15am, E2 (Director of Nursing - DON) stated, "When they went to put R26 in her wheelchair her leg got caught in the foot pedal. R26 is transferred with a mechanical lift. I write who is involved in the incident on a nurses note and the nurses note goes in a folder in E1 (Administrator) office." The folder with the nurses notes for incident investigations was requested. On 3/13/13 at 9:55am, E2 brought a stack of incident reports to the survey team and stated that it was all of the incidents and notes for the incidents. There were no additional notes for the incident on 12/9/12 for R26. On 3/12/13 at 10:40am, E4 (Restorative Nurse/ Licensed Practical Nurse) stated, "Education was done on transfers, mechanical lifts and body mechanics because the CNA's were hurting their backs. It is done with all of the CNA staff. The inservices are usually mandatory. There are only 50 to 60 percent of the CNA's that show up to the inservices." 2. The Incident Report dated 9/3/12 for R36 showed, "R36 was brought back to his room after his shower on a shower chair. Shower aide waiting for assistance to transfer, R36 began fidgeting, fell forward landing on the right side fetal position on the floor. Right arm under him;	F9999			

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F9999	<p>Continued From page 29</p> <p>head on the floor - 2cm round red area to right forehead. R36 moving extremities but guarding right hip. R36 assisted up with 3 assist and a gait belt. R36 yelled out when he attempted to put right foot down; Sent to the Emergency Room - Fractured Hip." The Incident Report dated 9/3/12 for R36 did not show who the shower aide was that was involved in the incident. The "Quality Assurance Review" (on the back of the Incident Report dated 9/3/12 for R36) showed, "Will assess proper transfer when returns."</p> <p>On 3/11/13 at 3:30pm, R4 stated, "The CNA's were not paying attention because they were talking to each other when they were transferring me using the mechanical lift. My toe hit the mechanical lift and that hurt. I didn't get stitches. They put steristrips on it."</p> <p>The Nurses Note dated 2/8/13 for R4 showed, " R4 noted to have a small skin tear to the left great toe. Cleansed with normal saline and applied steri-strips. "</p> <p>The Pain Assessment dated 2/8/13 for R4 showed she was complaining of pain to her left great toe.</p> <p>On 3/12/13 at 12:15pm, E2 (Director of Nursing - DON) stated, " I didn ' t know anything about R4 ' s toe. "</p> <p>On 3/12/13 at 10:40am, E4 (Restorative Nurse/ Licensed Practical Nurse) stated, " I didn't know anything about R4's toe. I should have been told if it happened during a transfer. "</p> <p>The Incident Report dated 4/17/12 for R32 showed, "Hospice Certified Nursing Assistant (CNA) reported she was transferring R32 to the chair when the chair moved. CNA lowered R32 to the floor."</p> <p>The Incident Report dated 5/28/12 for R33 showed, "R33 just reported that her right 5th toe</p>	F9999			

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F9999	<p>Continued From page 30</p> <p>was run over. Toe has a 1 cm round light pink bruise, non-raised and no open skin."</p> <p>The Incident Report dated 7/8/12 for R30 showed, "R30 stated that when being put into bed she was hit on the left eye with a bar on the mechanical lift. R30 noted to have a 2.5cm by 1.0cm swollen area to the left eye with bruising noted." The Incident Report did not show the names of the staff involved in the incident but stated that staff were educated on the back of the form.</p> <p>The Incident Report dated 7/21/12 for R34 showed, "CNA was assisting resident from the recliner to the wheelchair and had to lower R34 to the floor; Called to the room and noted gait belt on but no socks or shoes."</p> <p>The Incident Report dated 8/3/12 for R31 showed, "CNA reports the mechanical lift bar hit R31 while transferring him to bed; 1 cm scratch noted below the left eye." The Incident Report dated 8/3/12 for R31 did not show the names of the CNA's involved in the incident and The "Quality Assurance Review" on the back of the Incident Report showed, "Staff Education on mechanical lift transfers."</p> <p>The Incident Report dated 8/13/12 for R35 showed, " CNA's were doing AM care and when rolling R35 they bumped the right side of her head causing a red mark."</p> <p>The Incident Report dated 1/4/13 for R31 showed, "CNA's report R31's sock is saturated with blood. Upon inspection of the left little toe, a laceration was noted. Staff reports R31 was being sat upright in the reclining wheelchair and his foot hit on the chair." The "Staff " that reported the incident was not identified in the incident report and the Quality Assurance Review on the back of the Incident Report was blank and did not show</p>	F9999			

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F9999	<p>Continued From page 31</p> <p>responses to "Incident reviewed by the Interdisciplinary Team (IDT); Immediate Interventions; Care Plan Review or Comments/Ideas."</p> <p>On 3/13/13 at 3:40pm, E1 (Administrator) stated, "They (Incident Reports) don't show any follow through."</p> <p>3. The Physician Order Sheet (POS) dated 5/2012 lists R38's diagnoses to include C-7 vertebral fracture, Cirrhosis, Esophageal Varices, Dysphagia, and Abdominal Aortic Aneurysm. R38 was admitted to the facility on 5/24/12. R38's admission care plan states she is not to receive anything to eat or drink by mouth. R38 has a PEG (percutaneous endoscopic gastrostomy) tube related to dysphagia and NPO fluid restriction. The Minimum Data Set of 5/31/12 states R38 receives 51% or more of her fluid and 51% or more of her nutrition needs via a gastrostomy tube.</p> <p>The incident report dated 5/29/12 documents "R38 was given a general diet meal tray at suppertime in her room that was prepared by the kitchen staff and passed out as a room tray. There was no name card noted on the tray. There was no sign above the bed stating she was NPO. Resident consumed approximately 50% of the tray."</p> <p>On the back of the incident report it is documented the resident was monitored for signs and symptoms of aspiration. However, there was no resident assessment or follow up specific to the incident documented for R38 on 5/29/12 in the nurses' notes.</p>	F9999			

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F9999	<p>Continued From page 32</p> <p>On 3/13/13 at 10:20 AM, E2 (Director of Nurses) stated she could not recall the incident and was not sure how it happened (that R38 was served a general diet tray). E2 stated "CNA staff are informed of dietary restrictions verbally, on the delegate sheets and a sign should be posted in the room." E2 stated she did not have any investigation notes or follow up actions relative to the incident.</p> <p>On 3/12/13 at 3:20 PM, E12 (Registered Nurse) confirmed she was on duty during the shift when R38 consumed the general diet tray on 5/29/12. E12 stated R38 was a fairly new admission and was ordered NPO because she had dysphagia and received her feedings through a stomach tube (PEG). E12 stated R38 received a general diet and ate half of a sandwich before the error was discovered. E12 stated the CNA staff are informed of diet orders through their verbal report and on the delegate sheets.</p> <p>4. The Physician Order Sheet lists R6's diagnoses to include a History of Right Fractured Hip, Degenerative Arthritis and Bilateral Knee Replacements. The Minimum Data Set dated 4/1/12 shows R6 requires a mechanical lift for transfers and has range of motion limitation of both lower extremities.</p> <p>The incident report dated 10/6/12 at 9:00 PM states, "The CNA reports that the loop of the (mechanical) lift sling hit R6's left eye. The left eye noted to have periorbital redness with no edema, and the sclera was reddened, with a small amount of yellow drainage present."</p>	F9999			

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F9999	<p>Continued From page 33</p> <p>On the back of the unsigned incident report for R6 on 10/6/12, it is documented the plan was to investigate how it happened and in-service the staff.</p> <p>On 3/12/13 at 10:40 AM, E4 (Restorative Nurse - LPN) stated, "I believe we discussed the incident the next day during the morning meeting. E2 stated she was going to find out who was involved and follow up. It is out of my hands." E4 continued, "I wrote in the communication book that attention needs to be on what they are doing, this should not have happened." E4 added, "I have no idea who was involved in this incident". E4 stated she has in-serviced the staff on mechanical lift transfers but it was related to staff having back injuries and using poor body mechanics.</p> <p>On 3/12/13 at 10:45 AM, E1 (Administrator) stated, "This error is on the part of the people transferring R6. I have no idea who was involved." The surveyor requested the incident investigation and/or notes of the follow up actions taken. No report was submitted during the survey.</p> <p style="text-align: center;">(B)</p>	F9999		