STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145753	A. BUILDING _____ B. WING _____	C 04/03/2013

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DANVILLE CARE CENTER	**1701 NORTH BOWMAN DANVILLE, IL 61832**

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F 323	Continued From page 8 On 03/29/13 at 11:57am, E2, Director of Nursing (DON), stated that "It is my understanding that the bolsters should have been attached to the bed."	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.1210a) 300.1210b)5) 3001210d)6) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. b) The facility shall provide the necessary care and services to attain or maintain the highest	F9999		

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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:

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.

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:

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.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These requirements were not met as evidenced by:

Based on interview and record review, facility

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staff failed to use a mechanical lift for transfers prescribed in R1's care plan. R1 was dropped while being manually transferred by one staff person, resulting in fractures of the tibia and fibula. R1 is one of four residents (R1) reviewed for falls in the sample of five. The facility also failed to ensure that fall prevention interventions were implemented for R3. R3 is one of four residents reviewed for falls in the sample of five.

Findings include:

1. R1's Physician Order Sheet (POS) dated March 2013 documents the following diagnoses: Right Hemiplegia with Aphasia, Osteoporosis, History of Right Hip Fracture and Open Reduction Internal Fixation of Right Hip, Fractured Right Femur. The POS documents that R1 is to be transferred using a mechanical lift.

R1's Minimum Data Set (MDS) dated 12/31/12 documents that R1 is totally dependent on two or more staff for transferring and bed mobility, is unable to balance without staff assistance during surface to surface transfers, and has bilateral impairment of her upper and lower extremities. The MDS documents that R1 is moderately cognitively impaired.

R1's Care Plan dated 01/04/13 documents that she is to be transferred using the mechanical lift.

On 03/27/13 at 3:00pm, E15, Certified Occupational Therapy Assistant/ Licensed (COTA/L), stated that it was not safe for R1 to be transferred using a gait belt, and that R1 should be transferred using the mechanical lift.

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The Facility's Incident Report of R1's fall dated 03/24/13 at 7:00pm documents that R1's right knee and shin hit the floor when being transferred by two Certified Nursing Assistants (CNA) [E17 & E16].

R1's Nurse's Notes dated 03/25/13 document that R1 complained of pain and tenderness of her right leg, and bruising of the right leg was noted. R1's Physician was notified and an order for X-rays of R1's right lower leg was obtained.

R1's Radiology Report dated 03/25/13 documents "Slightly displaced communited fracture involving upper tibial shaft. Fracture is also noted involving proximal fibular shaft."

R1's Nurse's Notes dated 03/26/13 document that R1 was admitted to the hospital for treatment of the fractures.

On 03/27/13 at 2:41pm, E17, CNA, stated that on 03/24/13 the mechanical lift had worked when she used it to previously transfer six residents, but when she tried to use the mechanical lift to transfer R1, it would not work. E17 stated that she tried changing the battery, but that the mechanical lift would still not function. E17 stated that she then moved R1's wheelchair next to the bed and tried to transfer her to her bed with a gait belt. E17 stated that R1's knees buckled and one of her knees hit the floor. E17 stated that she and E16, CNA, then used a sheet as a lift device and lifted R1 into her bed. E17 then notified E18, Licensed Practical Nurse (LPN), who assessed R1's condition.

On 03/27/13 at 2:47pm, E16 stated that she had

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helped E17 get R1 into her bed from the floor using a sheet to lift her. E16 initially stated that she had helped E17 transfer R1 from her wheelchair, but on 04/03/13 at 9:44am E16 stated that E17 transferred R1 by herself. E16 stated that E17 came and got her to help put R1 in bed. E16 stated that when she got to the room, R1 was on the floor.

On 03/28/13 at 9:40am, E18, LPN, stated that E16 and E17 did not tell her that the lift was not working or ask her if R1 could be transferred without the lift prior to the attempt they made to transfer R1. While reporting R1's fall to E18, E17 told E18 that the mechanical lift was not working, and that they had tried to transfer R1 using a gait belt. E17 stated that they were unable to hold R1 and had lowered her to the floor on her knees. E18 stated that when she went to R1's room, R1 had already been placed in bed by E16 and E17.

On 03/29/13 at 10:30am, R1 stated that she fell because one CNA had tried to transfer her by herself without the mechanical lift. R1 stated that the CNA held her under her arm, tried to pick her up, and dropped her. R1 stated that the CNA told her that the mechanical lift wasn't working.

On 03/29/13 at 2:15pm, E1, Administrator, confirmed that R1 had been transferred improperly. E1 stated that E16 had been suspended on 03/28/13 at 2:00pm, and E17's employment had been terminated on 03/28/13 at 2:00pm.

On 03/28/13 at 10:30am, E19, Maintenance Director, stated that the facility has four mechanical lifts, three battery chargers, and 16

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batteries. E19 stated that all four mechanical lifts were in good working order on 03/22/13. E19 stated that a problem with charging batteries was reported to E20, Maintenance, on 03/26/13. E20 found one charger with a broken plastic clip which prevented a battery from being plugged in and charged, and the other two chargers were in good working order.

The Facility's Preventive Maintenance Checklist dated 03/22/13 documents that the four mechanical lifts had been checked and were in good working order.

2. R3's POS dated March 2013 documents the following diagnoses: Dementia and Osteoarthritis.

R3's MDS dated 10/26/12 documents that R3 is moderately cognitively impaired, and totally dependent on staff for transfers, activities of daily living (ADLs), and bed mobility. R3 has bilateral impairment of her upper and lower extremities. The MDS documents that R3 has a history of falls.

R3's Fall Risk Evaluations dated 10/26/12 and 01/17/13 document that R3 has a high risk of falls. On 03/29/13 at 2:00pm, E1, E2, and E23 stated that they could not find any Fall Risk Evaluations for R3 prior to 10/26/12.

R3's Care Plan dated 08/13/12 addressing R3's Risk for Falls documents "staff to ensure bed bolsters attached properly for safety."

R3's Accident/ Incident Report dated 10/26/12 at 12:10pm documents that R3 was found lying on the floor on her right side next to her bed. The

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F9999	Continued From page 14 Summary of Investigation of Root Cause was determined to be "Bolsters to bed not secure." Nurse's Notes dated 10/26/12 at 12:10pm document that R3 was found on the floor next to her bed on her R (right) side...bolster turned sideways on mattress on L (left) side of bed." R3's Post Fall Evaluation dated 10/26/12 documents "Staff educated to check and secure bolsters on resident's bed before lying resident down." On 03/29/13 at 11:57am, E2, Director of Nursing (DON), stated that "It is my understanding that the bolsters should have been attached to the bed." (B)	F9999		