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CASEYVILLE NURSING & REHAB CTR	**601 WEST LINCOLN AVENUE CASEYVILLE, IL 62232**

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F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1210b) 300.1210b)5 300.1210d)6 300.1220a) 300.1220b)8 300.3240a) 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 there under. 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	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 300.1220 Supervision of Nursing Services

a) Each facility shall have a director of nursing services (DON) who shall be a registered nurse.

b) The DON shall supervise and oversee the nursing services of the facility, including:

8) Supervising and overseeing in-service education, embracing orientation, skill training,

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and on-going education for all personnel and covering all aspects of resident care and programming. The educational program shall include training and practice in activities and restorative/rehabilitative nursing techniques through out-of-facility or in-facility training programs. This person may conduct these programs personally or see that they are carried out.

Section 300.3240 Abuse and Neglect

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)

These requirements were not met as evidenced by:
Based on observation , interview and record review the facility failed to follow their policy and manufacturers guidelines for safe use of a full body mechanical lift for 4 of 5 residents (R1, R2, R3 and R4) reviewed for full body mechanical lift transfers in the sample of 5. This failure resulted in a head injury, hospitalization and death of R2.

Findings Include:

1. R2 has diagnoses which include; Alzheimer's Dementia, Osteoporosis, history of Fractured Right Hip, and bilateral Deep Vein Thrombosis, with ongoing anti-coagulant therapy.

The Minimum Data Set dated 1/6/13 documents that R2 was totally dependant on staff, in all activities of daily living. It also documents that R2 had limited range of motion in both upper and

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lower extremities, and had poor balance.

A facility "Endurance/Functional Ability Assessment" dated 1/7/13 documents that R2 "is non-ambulatory, has no trunk control, poor sitting balance and is a mechanical lift for all transfers."

R2's Plan of Care which was last updated on 1/15/13 documents under both problem areas of 1) activities of daily living and 2) falls; "full mechanical lift transfers with 2-3 assists as needed."

Review of the facility Incident Tracking Log for the past three months documents that on 2/11/13, R2 Fell from the mechanical lift while being transferred.

The facility Patient Care Encounter form and incident summary, documents that two Certified Nurses Aids (CNA), E4 and E5 were in the room completing the transfer of R2 from her bed to a reclining wheelchair. During the transfer one of the 4 straps slipped off and R2 fell to the floor. "As a result (R2) fell forward, hitting her head on the air conditioning unit before falling to the floor."

The Local Hospital Emergency Room notes document that R2 was awake but confused upon arrival. A computerized tomography (CT) scan of the head was completed and showed an "acute diffuse subdural subarachnoid hemorrhage left frontal, parietal and temporal lobes." R2 was also given 2 units of fresh frozen plasma and Vitamin K to counteract bleeding in the brain. R2's blood pressure started to drop and she was intubated and placed on a ventilator at 9:30 AM. After consulting with Neurosurgery at a Trauma

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Center, R2 was transferred and admitted to their Neurosurgical Intensive Care. A repeat CT scan done 2/11/13 at 3:00 PM documents a "moderate sized subdural hematoma overlying left frontoparietal temporal lobes measuring up to 11 mm in greatest dimension. There is also moderate amount of subarachnoid hemorrhage in the left cerebral hemisphere."

A consultation by Neurosurgery on 2/11/13 documents under the area titled "Impression; Given the patients comorbidities and surgical comorbidities, we will attempt medical management to reverse coagulopathy to decrease bleeding."

A review of the hospital Expiration Summary dated 2/15/13 documents, "hospital staff met with family and due to the severity of the patients neurological injury.....the family decided to make her comfort care...and the patient was extubated and expired on 2/15/13."

During an interview on 2/14/13 at 11:40 AM, E5, one of the CNA's that assisted with the mechanical lift transfer involving R2 stated, " when I came in to help, (E4) already had the sling hooked up to the lift. We just started to lift her, then turned her towards the window, that's when the left lower strap slipped off and she went head first into the heater and hit her head." The sling was brand new and pretty stiff. I didn't double check the loops, she already had them hooked up when I came in. We were never told we had to specifically check the loops after we lifted a resident a little to make sure they were on OK.

In an interview on 2/19/13 at 12:30 PM E4, the

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second CNA assisting with the transfer of R2 on the day she was injured. E4 demonstrated how she performed the mechanical lift with R2. "(R2) had her head towards the window. I put the sling under her and hooked it up to the bar. Now I double check to make sure the loops are secure. I didn't check them that day but now I do. After I hooked it up I called (E5) in to help me She guided the resident. We turned the sling and resident towards the window because we had the reclining wheel chair facing the window. When we turned her the sling came off on the left and (R2) fell forward and hit her head on the window and air conditioner unit. (E5) stayed with the resident and I went to get help."

On 2/19/13 at 11AM E3 Licensed Practical Nurse (LPN), the nurse on duty the day of R2's fall, stated, (E4) came to get me, I went down to the room. I saw (R2) on the floor with her head in pool of blood under the air conditioner. She had a laceration to her fore head and her legs were laying over the legs of the lift. One strap had come off the bar. I called 911.

Review of the facility Policy for Mechanical Lift Transfers dated 8/29/09 documents under policy guidelines and interpretation, #4. " Staff will utilize mechanical lifts in accordance with manufacturers recommendations."

On 2/13/13, the E1 Administrator, provided a copy of the owners manual titled "Manual/Electric portable patient lift owners guide". This manufacturers guide documents, under various areas of the manual titled, "Lifting/moving the patient" page 28; "Transferring the patient" page 29; and

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"transferring to a wheelchair" page 32," black boxes with a highlighted WARNING. The warning states, " When the sling is a few inches off of the surface of the bed and before moving the patient, check again to make sure that the sling is properly connected to the hooks of the swivel bar. If any attachments are NOT properly in place, lower the patient back onto the stationary surface and correct the problem-otherwise injury or damage may occur."

2. On 2/14/13 at 11:25 AM E5,CNA and E8, CNA were observed completing a full mechanical lift transfer from bed to wheelchair involving R1. Sling loops were applied to the hooks of the swivel bar, and checked when initially applied while R1 was laying in bed. When R1 was lifted up and maneuvered towards the wheelchair, there was no second check for the safe placement of the loops on the hook of the swivel bar as recommended in the manufacturers guidelines. E5 CNA stated at 11:40 AM, "we were never specifically told to double check to make sure the loops were secure on the hooks."

3. On 2/18/13 at 12:45 PM E9 CNA and E10 CNA were observed transferring R4 from her wheelchair back to bed. The mechanical lift sling loops were applied to the hooks and checked initially but again no second check was completed on the safety of the loop to hook attachment, after the resident was elevated a short distance above the chair, but before moving her.

4. On 2/14/13 at 11:50AM E6 CNA and E7 CNA were observed completing a full mechanical lift from bed to wheelchair with R3. Sling loops were

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F9999	Continued From page 14 applied to the hooks on the swivel bar and checked initially. The resident was elevated, the sling was turned and the lift maneuvered around without a second check on the sling loops after elevating the resident. 5. In interview on 2/14/13 at 12:35 PM E12 CNA stated "we were never specifically told to double check the loops, you just know to check them when you first put them on." 6. In an interview on 2/14/13 at 1:50 PM E15, CNA stated, We check them when we put them on the bar before we lift the resident, then just start the lift." 7. When asked in interview to explain the mechanical lift procedure E13, CNA, stated that straps are checked when the loops are put on , she did not think they were checked any other time. 8. In an interview on 2/14/13 at 2:10 PM E14 CNA, when describing the lift procedure did not mention checking the placement of the loops at any time. (AA)	F9999		