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ILLINOIS KNIGHTS TEMPLAR HOME	450 FULTON STREET P O BOX 49 PAXTON, IL 60957

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F 520	Continued From page 64 on 3/10/13 resulting in her arm becoming entrapped in the tray was addressed in any QAA meeting or that educational training to the staff was provided after the 3/10/13 incident.	F 520		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.680a) 300.682a) 300.1210a) 300.1210b) 300.1210d)6) 300.3240a) Section 300.680 Restraints a) The facility shall have written policies controlling the use of physical restraints including, but not limited to, leg restraints, arm restraints, hand mitts, soft ties or vests, wheelchair safety bars and lap trays, and all facility practices that meet the definition of a restraint, such as tucking in a sheet so tightly that a bed-bound resident cannot move; bed rails used to keep a resident from getting out of bed; chairs that prevent rising; or placing a resident who uses a wheelchair so close to a wall that the wall prevents the resident from rising. Adaptive equipment is not considered a physical restraint. Wrist bands or devices on clothing that trigger electronic alarms to warn staff that a resident is leaving a room do not, in and of themselves, restrict freedom of movement and should not be considered as physical restraints. The policies shall be followed in the operation of the facility and shall comply with the Act and this Part. These policies shall be	F9999		

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F9999	Continued From page 65 developed by the medical advisory committee or the advisory physician with participation by nursing and administrative personnel. Section 300.682 Nonemergency Use of Physical Restraints a) Physical restraints shall only be used when required to treat the resident's medical symptoms or as a therapeutic intervention, as ordered by a physician, and based on: 1) the assessment of the resident's capabilities and an evaluation and trial of less restrictive alternatives that could prove effective; 2) the assessment of a specific physical condition or medical treatment that requires the use of physical restraints, and how the use of physical restraints will assist the resident in reaching his or her highest practicable physical, mental or psychosocial well being; 3) consultation with appropriate health professionals, such as rehabilitation nurses and occupational or physical therapists, which indicates that the use of less restrictive measures or therapeutic interventions has proven ineffective; and 4) demonstration by the care planning process that using a physical restraint as a therapeutic intervention will promote the care and services necessary for the resident to attain or maintain the highest practicable physical, mental or psychosocial well being Section 300.1210 General Requirements for	F9999		

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F9999	Continued From page 66 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 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. 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	F9999		

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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 observation, record review and interview the facility failed to identify a lap tray table as a strangulation/entrapment risk, failed to initiate new interventions, and failed to identify medical symptoms for use of the lap tray table after a fall for one of three residents (R12) reviewed for restraints in the sample of 13. R12 slid underneath the lap tray table becoming entrapped. The facility continued to use the device after the entrapment without any new assessment or interventions to provide for the safety of R12.

Findings include:

The Physician Order Sheet (POS) dated May 2013 for R12 documents the following diagnoses: Senile Dementia, Hypertension, Renal Insufficiency, Osteoporosis and Spinal Stenosis. The POS reflects a telephone order dated 9/11/12 for the use of a table tray.

The Minimum Data Set dated 3/4/13 for R12 documents severe cognitive impairment.

The facility's document titled "Pre-Restraining

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Assessment" and dated for 9/13/12 documents R12's balance as, leans forward, leans sideways to the left, and slides down. Under ambulation the document notes R12 as unsteady on feet, history of falls and is able to take short steps. R12's fall risk assessment dated for 3/6/13 documents R12 as high risk for falls.

On 5/2/13 at 5:10 pm R12 was in the dining room sitting upright in her wheelchair with good trunk control. R12 had restless behaviors during the meal, attempting to get out of her wheelchair several times.

On 5/3/13 at 9:00 am R12 was sitting upright in her wheelchair with good trunk control, the tray table was in place. R12 was self-propelling down the hall.

The facility's policy titled "Physical Restraint Policy And Protocols for Reduction states: "A restraint is any device designed to limit movement to protect resident from injuring self and others. Restraints include lap cushions and lap trays, bed rails to keep resident from voluntarily getting out of bed, chairs that prevent rising (reclining geriatric chair, belts, and self-release devices). Any resident who a physician prescribes a physical restraint for, must have a Physical Restraint Reduction Assessment completed at the time the order is obtained by the attending physician." The facility policy does not direct staff to identify any medical symptoms warranting restraints used in their facility.

The facility document titled "Resident Accident Report" and dated 3/10/13 documents the following fall with no injury for R12. R12 was discovered sitting on the floor in front of her

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wheelchair with her left arm up under the lap tray table with table attached to wheelchair. No new intervention was put in place and no reassessment of the physical restraint was done. The lap tray table was continued.

On 5/2/13 at 5:25 pm E10, (CNA) stated that R12 was known to slide down under her lap tray table and stated "Oh yeah she can slide down and get out of the chair, she is a regular Houdini, even over the pummel cushion. She can get out of just about anything." On 5/3/13 at 1:20 pm E13, Licensed Practical Nurse (LPN) stated that he was very familiar with R12 and has cared for her numerous times. E13, LPN stated that R12 is checked on ..."I know at least every hour, and she has been found to have slid down in her wheelchair trying to get out, but we just pull her up."

R12's Care Plan dated 3/6/13 documents R12 as being at an increased risk for falls due to her poor safety awareness and her history of falls. R12 is to have a Lap Tray when up in wheelchair to help with posture and positioning and R12's lack of safety awareness. There is no approach or direction to staff documented in the Care Plan for any type of monitoring for the risk of entrapment or strangulation in association to R12 and the lap tray table. The Care Plan does not address any new intervention following the 3/10/13 fall and R12's subsequent entrapment in her lap tray table.

On 5/7/13 at 3:15 pm Z1 (R12's Healthcare Power of Attorney) stated that he was told by the facility that the restraints were used on R12 because of her falling all the time and they were to keep her from getting out of her wheelchair

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F9999	Continued From page 70 and falling. (A) 300.1210b)5) 300.1210d)6) 300.2420j) 300.3240a) 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 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	F9999		

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F9999	Continued From page 71 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 300.2420 Equipment and Supplies j) There shall be a sufficient quantity of resident care equipment of satisfactory design and in good condition to carry out established resident care procedures. 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 observation, interview, and record review, the facility failed to ensure the safety of a mechanical lift for one of six residents (R6) reviewed for falls in the sample of 13. R6 was dropped from a mechanical lift on two separate occasions as a result of the lift's mechanical failure. R6 is one of six residents reviewed for falls in the sample of 13. These failures have the potential to affect four other residents (R18, R27, R28, R29) who use the full mechanical lifts for transfers. Findings include:	F9999		

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R6's Physician Order Sheet (POS) dated May 2013 documents the following diagnoses: Old Cerebral Vascular Accident (CVA) with Residual (Left Side Hemiparesis), Left Ankle Fracture with Open Reduction and Internal Fixation, Osteoarthritis, and Anxiety.

R6's Minimum Data Sets (MDS) dated 10/01/12 documents that R6 requires extensive assistance with transfers, and that R6 has bilateral upper extremity impairment and impairment of one lower extremity. R6's MDS dated 02/10/13 documents that R6 is totally dependent on staff for transfers. R6's MDS dated 02/10/13 documents that R6 has bilateral impairment of her upper and lower extremities and is totally dependent on staff for bed mobility.

R6's Fall Risk Assessments dated 10/02/12 and 12/23/12 document that R6 was at risk for injury from falls.

R6's Care Plan was updated on 12/05/12 and documented that R6 transfers using a full mechanical lift.

The Facility's Resident Accident Report dated 01/03/13 at 1:05pm documents that R6 fell again from the full mechanical lift as she was being lifted to her bed by E11, Registered Nurse (RN) and E12, Certified Nursing Assistant (CNA). R6 fell from the air when being raised by the full mechanical lift, landed on another resident's bed, and then fell onto the floor. R6 sustained no injury. The Report documents the cause of the event as "Lift malfunction, mechanical failure." The documented Corrective Actions Taken on 01/03/13 is "Maintenance department to assess the lift." Follow up, dated 01/04/13, was "[full

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mechanical lift] taken out of service, [checked] by maintenance, new parts ordered, checked weekly by maintenance."

On 05/03/13 at 9:52am, E12, CNA, stated that she and E11, RN, transferred R6 on 01/03/13 at 1:05pm using the full mechanical lift. E12 stated that when R6's wheelchair was pulled back from under the resident and sling, the lift fell over on its side and "bolts came out of one leg of the [lift]."

On 05/03/13 at 10:02am, E11, RN, stated that she and E12 had attempted to transfer R6 on 01/03/13 using the full mechanical lift. E11 stated that the lift collapsed as they began to move the lift forward (with R6 in the air), and that "a pin fell out of the [lift]." E11 stated that she immediately called maintenance and notified them of the lift's failure.

The Facility's Resident Accident Report dated 02/28/13 at 12:45pm documents that R6 fell from the full mechanical lift to the floor while being transferred to her bed by E14, CNA, and E20, CNA. The report documents that the full mechanical lift tipped over onto its side during the transfer. R6 sustained no injury. The documented Cause of Event was "Possible lift malfunction--Res [resident] wt [weight]--lg [large] body mass." The Corrective Action taken was "Lift taken out of service. Staff in-serviced (reinserviced) on proper use of a lift."

The Weekly Lift and Sling Check document that the full mechanical lift #2 was out of order on 03/03/13 (two days after the last fall).

On 05/03/13 at 9:45am, E14, CNA, stated that the full mechanical lift appeared normal prior to

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F9999	Continued From page 74 using it to transfer R6 on 02/28/13. On 05/03/13 at 9:57am, E20, CNA, stated that on 02/28/12, she and E14 transferred R6 using the full mechanical lift. E20 stated that R6 was lifted into the air and as the lift was pushed forward toward R6's bed, it fell onto its side, causing R6 to fall onto the floor. E20 stated that the top piece of the lift (boom) appeared bent after the fall. On 05/03/13 at 9:15am, E8, Maintenance Director, stated that he does not remember the incident on 01/03/13 involving use of the full mechanical lift. E8 stated that he may have been notified of the incident and that he may have ordered parts for the lift. E8 stated that he often orders parts to repair each of the four lifts, but he does not document what repairs are made on which lift, when the lifts are taken out of service, or when the lifts are returned to service. E8 was unable to produce a purchase order or any documentation of which repairs were made to which lift. E8 stated that following R6's fall on 02/28/13, the full mechanical lift #2 appeared to have a bent boom, so lift #2 was taken out of service and a new lift was ordered to replace lift #2. On 05/03/13 at 1:20pm, E8 stated that after reviewing the Weekly Lift and Sling Check, he is certain that lift #1 was the lift used with R6's transfer on 01/03/13. The Weekly Lift and Sling Check document that the full mechanical lift #1 was out of order on 01/05/13 (two days after the fall) and 01/12/13, and that it was back in use on 01/20/13 during the weekly check. E8 was unable to identify when lift #1 was put back into use. E8 stated that he cannot remember what was wrong with the lift, what was replaced, or when it was	F9999		

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repaired. E8 was unable to produce any record of repairs or servicing to lift #1. E8 stated that a purchase order was placed on 03/04/13 for a full mechanical lift. The new lift replaced lift #2.

On 05/03/13 at 9:20am, E19, Maintenance Staff, stated that he did not remember any incidents involving the full mechanical lifts or any repairs completed on the lifts in January or February 2013.

The Weekly Lift and Sling Check document that the facility maintains four lifts: two full mechanical lifts and two stand aid lifts.

On 05/07/13 an Internet purchase order was retrieved by E1, Administrator, for an order placed on 01/03/13 for "a replacement handle mount; a lift part, spring compression; lift part, screw shoulder; and lift part, tie rod." A purchase order was also retrieved for an order placed on 03/04/13 for a "[Mechanical] Floor Lift, Powered Low-Height Base" (four days after the fall of 02/28/13).

On 05/08/13 at 10:00am, E1 stated that no other documentation was available for what repairs were made to which lift, the final status of the lift prior to being put back into use by staff, or when the new lift was put into use.

On 05/08/13 at 10:00am, E1 produced a typed statement signed by E19 on 05/08/13 which states that lift #1 was taken to the maintenance department on 01/03/13, with a bent left tie rod and loose bolt. The statement reported repairs being made on 01/14/13. E1 stated that she did not know why E19 was unable to report this information on 05/03/13 at 9:20am when asked

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F9999	Continued From page 76 by the surveyor. The Facility's undated [Full Mechanical Lift] Procedure does not direct staff to observe the lift for loose, missing, or bent parts prior to performing resident transfers using the full mechanical lift. On 5-3-13 E1, Administrator provided a list of four additional residents requiring the use of a full mechanical lift which included R18, R27, R28, and R29. (A)	F9999		