

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

PRINTED: 03/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145411	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/05/2013
NAME OF PROVIDER OR SUPPLIER PRAIRIE ROSE HEALTH CARE CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 900 SOUTH CHESTNUT PANA, IL 62557		
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F 323	Continued From page 5 reposition R1, E4 stated "I've been a CNA for 15 years." On 12/4/13, at 11:00 AM, in a telephone interview, Z1 (Medical Doctor) stated that R1 has "really osteoporotic bone and rigidity of the knee." Z1 further stated that the ankle fracture could have resulted from turning. Z1 stated that R1 has probably had osteoporosis ever since R1 has had the arthritis. On 12/3/12, at 8:30 AM, in an interview, E2 (Director of Nursing) stated she was unaware of any incident that occurred with R1 on Tuesday 11/26/13 regarding her right foot being caught in the geri-chair. On 12/3/12, at 8:35 AM, in an interview, E1, Administrator, stated she was aware of R1's right foot being caught in her geri-chair on Tuesday 11/26/13. E1 further stated that she did not know of the incident until after the investigation of R1's ankle fracture was initiated. E1 stated E5 did not report the incident to any staff or have R1's right foot assessed after being caught in the geri-chair.	F 323			
F9999	FINAL OBSERVATIONS STATEMENT OF LICENSURE VIOLATIONS 300.1210a) 300.1210b) 300.1210d)3)6) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care	F9999			

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F9999	Continued From page 6 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. (Section 3-202.2a of the Act) 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be	F9999			

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F9999	<p>Continued From page 7 made by nursing staff and recorded in the resident's medical record.</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 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.(Section 2-107 of the Act)</p> <p>These requirements are not met as evidenced by:</p> <p>Based on observation, record review, and interview, the facility failed to assess for contractures; implement interventions based on the assessment; and thoroughly investigate a fracture for 1 of 3 residents (R1) in the sample of 3. This failure resulted in R1 sustaining a fracture to her right ankle.</p> <p>Findings include:</p> <p>R1 was originally admitted to the Facility on 1/16/06 with diagnoses, in part, of Cerebral Artery Occlusion, Cerebrovascular Accident with right hemiplegia and Severe Osteoarthritis. Hospital History & Physical dated 3/26/07 documents in part, R1's history includes severe osteoarthritis.</p> <p>The Facility "Final Investigation Report" documents: "Account: On 11/27/13, it was</p>	F9999			

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F9999	<p>Continued From page 8</p> <p>reported that during morning care, R1 complained of ankle pain. E7, Licensed Practical Nurse (LPN) assessed R1's right foot and noted abnormalities. E7 notified the Administrator, Physician and called for a stat x-ray. Stat x-ray was then cancelled due to time frame to get portable x-ray to Facility and R1 was sent to the emergency room for the x-ray. X-ray results indicated diffuse osteopenia and fracture involving the distal right tibia and fibula.</p> <p>Investigation: E4, Certified Nurses Aide (CNA) stated that she and E8, CNA, were in the room getting R1 dressed and ready to get up. E4 was on the side of the bed near the wall and E8 was by the night stand. E4 had the mechanical lift sling rolled and ready to place under R1's buttocks while E8 turned her. As E8 started to turn R1 screamed and stated "my ankle". E4 told E8 to let R1 go. R4 stated R1's ankle was up underneath of her (R1 does have contractures of the lower extremities). R1 then complained of knee pain when they moved her leg. R1 then again stated that her ankle hurt. As E4 and E8 were coming out of R1's room, the day shift CNA's, E6 and E5, were waiting for report from the two night shift CNA's. The day shift CNA's immediately reported R1's complaint of ankle pain to the nurse.</p> <p>E8 stated she was by the night stand and she had hold of the pad to turn R1 towards her. R1 started yelling. R1 stated "my ankle, my ankle" as E8 went to lay her back. E8 stated that they noticed R1's foot was curled under her after turning her. E8 stated that before R1 was turned she did move her foot down a little bit. E8 stated she did not notice R1 had curled her ankle back up under her. E8 stated that she did report the</p>	F9999			

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F9999	<p>Continued From page 9</p> <p>incidents to the day shift CNA's as incident did occur right at shift change. E5 stated E4 told her R1's foot was under her bottom when they rolled her over and she hollered out. E5 and E6 then went in to get R1 up. The lift sling was already under her and they went to fix the pad under R1. E6 started to roll R1 to her side and she screamed. They immediately stopped and noted that R1's right ankle stayed flat on the bed and her leg came up. E5 immediately reported the incident to E7.</p> <p>Conclusion: The Facility is unable to determine the exact cause of the fracture. Upon interview with R1's primary care physician, he stated that he believed the fracture could have occurred while she was being turned because her bones are so brittle. The Facility is unable to determine any willful intent by either staff member".</p> <p>The Facility investigation into this incident does not document the potential causative factors for R1's ankle fracture nor is there documented corrective actions to prevent further injury to R1. During an interview with E1, Administrator, on 12/2/13 at 2:30 PM, it was stated that she thought she could not put conclusions in an investigation.</p> <p>R1's Emergency Room record, dated 11/27/13, documents, in part, R1's "knee contracted bilateral, unable to straighten right knee". The Diagnostic X-Ray Imaging of R1's right lower leg and ankle, also dated 11/27/13, documents "the bones are diffusely osteopenic. There is a fracture through the distal metaphysis of the right tibia which appears to be comminuted. There is some impaction of the fracture as well. There is apparent distal right fibular fracture as well. There is some medial angulation of the medial</p>	F9999			

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F9999	<p>Continued From page 10 lateral malleolar fracture fragments on the cross-table view."</p> <p>R1 was re-admitted to the facility from the hospital on 12/2/13 at 11:00 AM, with a cast on her right leg and foot. R1's right lower leg is contracted at a 90 degree angle and drawn up to her knee level.</p> <p>R 1's Minimum Data Set (MDS), dated 10/25/13 documents, in part, that R1 is unable to complete the Brief Interview of Mental Status (BIMS); is totally dependent on two or more staff for transferring, dressing, hygiene, toileting, and bathing; unable to ambulate; and has severe limitations of both upper and lower extremity range of motion.</p> <p>R1's Care Plan dated 8/2/13, documents, in part, that R1 is dependent on staff for Activities of Daily Living (ADL's) and is "totally dependent on staff for transfers D/T (due to) leg contractures". The Care Plan does not address how to transfer, turn or reposition R1 due to her right leg contracture.</p> <p>On 12/2/13, at 1:45 PM, in an interview with E6 (CNA), when asked how she (E6) knows how to turn and reposition R1, E6 stated she is trained by nursing staff and CNA's who have been at the facility longer.</p> <p>On 12/2/13, at 2:20 PM, during a telephone interview with E5, when asked how she (E5) knows how to turn and reposition R1, E5 stated by working with residents and seeing what works best.</p> <p>The most recent assessment of R1's functional skills dated 3/25/11, documents R1's right lower</p>	F9999			

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F9999	<p>Continued From page 11</p> <p>extremity as "right knee contracted". On 12/5/13, at 1:00 PM, during an interview, E2 (DON) stated that this is the most current assessment of R1's functional abilities.</p> <p>During an interview with R1 on 12/2/13, at 1:17 PM, R1 stated she did not know what happened to her right leg or why she has a cast. When R1 was asked about her recent hospitalization she stated "I didn't know.....".</p> <p>On 12/4/13, at 2:20 PM, in a telephone interview with E8 (CNA), E8 stated that E4 (CNA) and E8 were dressing R1 on 11/27/13 at around 5:30 or 6:00 AM when R1 was rolled to the left and R1 yelled out "my ankle!" E8 stated she noticed R1's foot was tucked underneath her buttocks. E8 stated she did not report the incident or have R1's right foot assessed by nursing staff, but "mentioned it to oncoming CNA's."</p> <p>During an interview with E1 and E2 on 12/5/13 at 1:40 PM, E1 stated "If the CNA's think there is something wrong they should tell a nurse as soon as they can but there is no time frame".</p> <p>On 12/2/13, at 3:40 PM, in a telephone interview with E4 (CNA), E4 stated that on 11/27/13 at 5:50 AM, E8 and E4 were dressing R1 when R1 screamed out "my ankle!" when rolled to side. E4 stated that day shift CNA's were told to watch R1's ankle because R1 was complaining of pain. E4 further stated that R1 had her right ankle caught in her geri-chair the previous day, 11/26/13. E5 stated that R1's right foot was caught where the geri-chair folded up and R1 had complained of pain to her right foot on 11/26/13. E4 stated that E5, CNA told E4 about this incident the on 11/26/13. E4 stated she did not report this</p>	F9999			

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F9999	<p>Continued From page 12</p> <p>to anyone and stated that E8 "told E1(Administrator) what she needed to know." When asked E4 how she knows how to turn and reposition R1, E4 stated "I've been a CNA for 15 years."</p> <p>On 12/4/13, at 11:00 AM, in a telephone interview, Z1 (Medical Doctor) stated that R1 has "really osteoporotic bone and rigidity of the knee." Z1 further stated that the ankle fracture could have resulted from turning. Z1 stated that R1 has probably had osteoporosis ever since R1 has had the arthritis.</p> <p>On 12/3/12, at 8:30 AM, in an interview, E2 (Director of Nursing) stated she was unaware of any incident that occurred with R1 on Tuesday 11/26/13 regarding her right foot being caught in the geri-chair.</p> <p>On 12/3/12, at 8:35 AM, in an interview, E1, Administrator, stated she was aware of R1's right foot being caught in her geri-chair on Tuesday 11/26/13. E1 further stated that she did not know of the incident until after the investigation of R1's ankle fracture was initiated. E1 stated E5 did not report the incident to any staff or have R1's right foot assessed after being caught in the geri-chair.</p> <p>(B)</p>	F9999			