Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009989	A. BUILDING: ______ B. WING ______	08/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON LIVING AND REHABILITATION CENT	**811 SOUTH 10TH STREET OREGON, IL 61061**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Final Observations	S9999		

Statement of Licensure Violations:

300.1210b)
300.1210d)6)
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.

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

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S9999	Continued From page 1	S9999		

agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)

These Requirements are not met as evidenced by:

Based on interview and record review the facility failed to ensure a resident's safety during a mechanical lift transfer. This failure resulted in R1 sliding out of the mechanical lift sling onto the floor and sustaining a fracture of the right leg on 1/12/14.

This applies to 1 of 13 residents (R1) reviewed for safety in a sample of 15.

The findings include:

1. The Minimum Data Set of 6/12/14 shows that R1 scored a 12 on the Brief Interview for Mental Status (Moderate Cognitive Impairment). This same document also shows that R1 is totally dependent on 2 or more staff for transfers.

R1's Nurse's Notes(NN) dated 1/12/14 shows that state,"CNA(Certified Nursing Assistant) reported to nurse that resident slid out of (mechanical)sling and onto floor. (Mechanical) sling was up too far on resident's body. CNAs saw resident hit his head on the foot rest of is wheelchair....Resident complained of right leg hurting but can not pinpoint spot." The NN dated 1/13/14 state, "New order received to x-ray right knee." and "New order to send to ER for eval and treat."

The facility Incident Report dated 1/12/14 states, "CNAs reported to nurse that resident slid off of (mechanical) lift sling prior to being lifted and onto

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S9999	Continued From page 2	S9999		

the floor. CNAs reported that resident hit his head on foot rest of his wheelchair....resident does complain of right leg hurting but cannot pinpoint the pain."

R1's right knee X-ray report dated 1/13/14 states, "There is an acute mildly displaced fracture of (the) medial femoral condyle."

On 8/13/14 at 3:30 PM, R1 stated, "I was getting ready to go to bed. I was lifted up in the (mechanical)lift sling and then I fell out onto the floor. I landed on my right side. The CNAs told me the (mechanical) sling was too short. I fell about a foot (the drop was about a foot). I broke my leg just above my knee cap."

The undated written statement from E13 (Certified Nursing Assistant-CNA) states, "On 1/12/14, (E14- CNA) and I went into (R1's) room to prepare him for bed. We hooked the sling up to the (mechanical lift) and pumped once or twice, (R1) then slipped off the wheelchair cushion onto the floor prior to us lifting him up. (R1) bumped his head on the foot rest of his chair and complained of his knee hurting..."

The written statement from E14 dated 1/13/14 states, "On 1/12/14 while preparing (R1) for bed, E13 and I hooked the handles to the (mechanical lift) and pumped only once or twice. (R1) then slid off the (mechanical lift) sling and on to the floor. ... (R1) seemed to slip off the sling due to it being slippery. When he slid to the floor he bumped his head on the foot rest and complained he bumped his right knee...(E13) and I were unable to prevent him from slipping because it happened so fast."

An untitled facility document dated 1/14/13 states,

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S9999	Continued From page 3 "From all the info I gathered, I am concluding this-that the (mechanical lift) sling was positioned up too far underneath him, but that when the staff removed his seatbelt from the chair and got him in position to transfer that he slid off the sling-while his bottom was still on the seat." (B)	S9999		