STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145404	A. BUILDING _____ B. WING _____	C 06/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FARMINGTON COUNTRY MANOR	**701 SOUTH MAIN STREET FARMINGTON, IL 61531**

(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) COMPLETION DATE
F 000	INITIAL COMMENTS Facility-reported Incident Investigation to incident date of 6/7/21/IL134792.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure a resident was transferred according to their plan of care for one (R1) of three residents reviewed for transfers in a sample of three. This failure resulted in R1 sustaining a femur fracture and increased pain. Findings include: Facility "Safe Lifting and Movement of Residents," dated 1/1/16, documents "In order to protect the safety and well-being of staff and residents, and to promote quality of care, this facility uses appropriate techniques and devices to life and move residents." R1's facesheet documents R1 was Admitted on 5/24/21 and Re-admitted from the hospital on 6/10/21. R1's medical record documents under her current diagnoses the following: "Osteoarthritis,	F 689	The facility implemented interventions to keep the environment as free of accident hazards as much as possible and provide adequate supervision and assistance devices to prevent accidents. The facility identified and evaluated hazards and risks, and then implemented interventions to reduce these hazards and risks. This included for R1 upon admission 05/24/2021: care plan documented two person assist with mechanical lift; MDS documented that R1 is cognitively intact, and requires total assistance of two with transfers; Care Card posted in resident closet documented uses a wheelchair is a total lift with assist of 2; and R1 has trapeze over bed and use of mechanical lift with sling. After the incident of 6/7/2021, R1 returned facility on 06/10/2021. Orthopedic Consultation note recommended	6/28/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/28/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 689	Continued From page 1 weakness, fracture of left femur (9/12/20), Chronic inflammatory demyelinating polyneuritis (Autoimmune disease that affects the nerves in the arms and legs)." R1's careplan documents an onset date of 5/24/21 for the following: "I am unable to transfer independently, and I am a two assist and hoyer lift for all transfers due to declining disease process and weakness." R1's MDS (Minimum Data Set), dated 5/31/21, documents R1 is cognitively intact, and requires total assistance of two for transfers. On 6/15/21 at 1:40pm, R1 was in her bed with a trapeze over the bed, hoyer sling in her wheelchair, right leg in an immobilizer, and was alert and oriented. On the inside of R1's closet door, R1's "carecard" posted in R1's closet, dated 5/25/21, documents R1 is "Alert and oriented, non-ambulatory, uses a wheelchair is a (total) lift with an assist of two. Staff assist of two with (total lift) for all transfers and hospice." There was also a note posted in capital letters and bold face in R1's closet, no date, documents "Resident is to be staff assist x2 for all cares and transfers- no exceptions!!! Resident is to be a hoyer lift at all times with staff assist of two." At that same time, R1 stated "One CNA (V3 Certified Nurse Aid) transferred me by herself without a lift and it was supposed to be two people with the lift. (On 6/7/21), I was sitting at the edge of the bed and (V3 CNA) put me in the wheelchair by herself. I did not have pain right away; it took a while for the pain to come and when it did it was bad. I got pain meds and an X-Ray for my right leg. They had always used two people and used the lift with me prior to (6/7/21)."	F 689	conservative treatment at this time. Assessment was completed by Physical Therapist, Director of Nursing and Restorative Nurse in collaboration with R1 and V9 (POA). Plan of Care and Care Card were updated to include knee immobilizer to right lower extremity. Direct care staff were educated on revised instructions needed for care to R1. R1 had an effective pain management program prior to incident on 06/07/2021 and then it was updated upon return of on 06/10/2021. As a result of this one accident, the employment of V3 was terminated on 06/18/2021 after investigation was completed. The last day of employment for V3 was 06/07/2021. All remaining residents having the potential to affected by the same practice were reviewed based on transfer status, including use of mechanical lifts. Care Cards were verified for accuracy and additional training on safe resident lifting was immediately initiated by Staff Development Director. No other issues were noted. One measure the facility took to ensure the problem was corrected included conducting an Emergency Safety Meeting as part of the Quality Assurance Performance Improvement (QAPI) process to determine root cause analysis of how the fracture occurred. After a careful and thorough evaluation of facility	

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F 689	Continued From page 2 R1's "Resident Incident Report," dated 6/7/21, documents "(R1) states she was transferred without a hoyer, pain to right knee, non-pitting edema, and redness to knee without heat." R1's "Incident Investigation," dated 6/7/21 by V7 RN (Registered Nurse), documents "CNA (V3 Certified Nurse Aid) transferred (R1) to the wheelchair and then (R1) started having pain in her right leg and knee area. Tried to reposition (R1) without success. Hospice nurse, CNA, and floor nurse transferred (R1) back to bed to assess (R1). (R1's) right knee is more swollen than the left and (R1) complains of pain with Morphine given. Hospice nurse instructed (V7) to get an X-Ray and if (R1) continued to have pain which (R1) did. X-ray done and showed a fracture of the distal femur. (R1's) medical doctor gave orders to keep (R1) comfortable for the night and if pain not controlled to send (R1) to the ER (Emergency Room)." R1's "Incident Investigation" notes, dated 6/8/21 by V2 DON (Director of Nursing), documents "Assessed (R1's) right leg and her right knee is more swollen than the left. (R1) has intense pain with any kind of attempted movement. (R1) decided she would go to the ER and was sent by ambulance to (local) hospital. (R1) was admitted to the hospital with an ortho consult the next day. After interviewing staff and talking with the staff member (V3 CNA) that transferred (R1) inappropriately, I informed (V3) that she was suspended until my investigation was finished." This form further documents V2 DON re-educated staff on transfers and resident care cards.	F 689	comprehensive systems, the committee determined that the facility had in fact implemented an inclusive system in which interventions, including supervision consistent with the needs, goals and plan of care for R1 were in place. This accident occurred despite the systematic approach implemented by the interdisciplinary team and that V3 failed to follow the plan of care one time which resulted in the fracture to R1. This information was given to surveyor during investigation. Per QAPI Emergency Safety Committee recommendations of 06/08/2021, the Staff Education Director began immediately re-educating all certified nursing assistants individually on facility's processes for ensuring resident safety, including care cards, plan of care, staff supervision and equipment required to prevent accidents. This was completed on 06/14/2021. Also, Director of Nursing completed QAPI recommendation of re-education licensed staff on facility policy and procedure for addressing change in resident condition, including leadership, physician and family. This was completed on 06/14/2021. A Focus Group was conducted with certified nursing assistants on 06/18/2021. As a result of the input from staff, an additional measure was added to the existing system on 06/21/2021. A Visual Image of a Mechanical Lift (Hoyer) or Sit To Stand Lift was added to each resident wall where a mechanical lift is required for	

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F 689	Continued From page 3 V3's employee file has a document titled "Employee Warning Report," dated 6/7/21, which documents "On 6/7/21 at 10:50am you transferred (R1) inappropriately and caused her pain." This form further documents on 6/8/21, V3 was put on immediate suspension, V3 did not come in to sign the form, and V3 did not do a witness statement but acknowledged the suspension through text messages. R1's "Long-term care- Serious Injury Incident Report", dated 6/9/21 by V2 DON (Director of Nursing), documents "(R1) is interviewable, makes informed decisions, alert and oriented, and R1 had an incident on 6/7/21 where an assessment was performed on 6/7/21 at 12pm. (R1) was sent to the hospital ER (Emergency Room) on 6/8/21 at 1:45pm for an X-Ray where R1 got the diagnosis of a "closed fracture of distal end femur of the right leg." Ortho was consulted and ordered an immobilizer to R1's right leg, continue pain control, and non-weight bearing to right leg. I have discussed with staff about her transfers, positioning, and activity of daily living." R1's hospital notes from (local) hospital, dated 6/8/21 at 3:11pm documents "(R1) presenting to the Emergency Department for evaluation of leg pain. Patient states she is normally moved by hoyer at the nursing home but states a staff member physically lifted the patient yesterday (6/7/21). Patient denies falling and is complaining of right leg pain, pain is present in the right thigh, nothing relieves the pain, and tenderness to the entire right femur." R1's hospital X-Ray, dated 6/8/21 at 4:59pm, documents "The patient has a mildly impacted transverse distal femoral shaft fracture."	F 689	transfer assistance to serve as an another safety reminder. Licensed and certified staff were educated on this upgraded safety measure by Staff Education Director. This was completed 06/25/2021. This new visual alert component was also added to the orientation program for new direct care staff and will be reviewed annually. A new random audit was created to ensure direct care staff are following the enhanced safety measures enacted by facility to ensure the safest environment possible for residents. This audit will be completed on 10 residents weekly for 10 weeks by Staff Education Director or designee to ensure compliance is achieved. This was initiated on 06/25/2021. The Quality Assurance Performance Improvement(QAPI)Committee will review the results of this audit. By monitoring the facility's performance, the committee will make any necessary suggestions to ensure the correction is achieved and permanent. It will also confirm that systematic changes identified in this plan of correction, have been put in place so the deficient practice does not recur. The facility initiated a program to monitor the performance of this plan of correction during QAPI Committee meetings. The QAPI Committee will review this plan monthly until this correction is sustained. The QAPI Committee will evaluate the effectiveness of this plan and integrate it	

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F 689	Continued From page 4 R1's Orthopedic Consultation note, dated 6/9/21 at 8:09am, documents "R1 is 91 years old, recommend conservative treatment at this time. Knee immobilizer to the right lower extremity." R1's nurses notes document the following: On 6/3/21 R1 had no complaints of pain, was on hospice, and transferred by a lift; on 6/7/21 R1 was to be discharged from hospice on 6/10/21; on 6/7/21 at 5:39pm R1 complains of pain to right knee, right knee area is edematous and red, Tylenol #3 given but not effective for pain, Morphine 5mg given for pain, x-ray notified for x-ray of right knee/tibia/fib; X-ray report documents R1 has a "Transverse, displaced supracondylar fracture of the distal femur"; on 6/8/21 at 4:27am and 5:22am R1 complained of pain to right leg, and right leg from knee down edematous and painful to the touch; on 6/8/21 at 3:13pm R1 continued to have swelling and increased pain, and R1's daughter here and they decided to go to (local) hospital for evaluation and treatment; and on 6/10/21 at 2:20pm, R1 was admitted back to the nursing home with a fractured distal right femur with her right leg in a binder. On 6/15/21 at 12:10pm, V2 DON stated "(R1) did not have a fall, her leg got twisted and fractured from a transfer. She was on hospice at the time, (R1) did not want to go to the hospital, daughter came in the next day and talked to (R1) and (R1) agreed to go to the hospital ER for an evaluation. A CNA (V3) transferred (R1) by a stand pivot but (R1) did not pivot when (V3) put (R1) into the wheelchair. (R1) was a hoyer with two-person transfer but was transferred by one-person assist. After my investigation I immediately suspended	F 689	into the quality assurance system. This will ensure these corrections are achieved and permanent.	

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F 689	Continued From page 5	F 689		

(V3). (R1) went to the hospital, got diagnosed with a femur fracture, and came back (to the nursing home) with a knee immobilizer. (R1) has needed to take pain medication since the incident. All residents have carecards in their closets, so the staff know how to transfer residents, (V3) knew how (R1) transferred, and the carecards have been used here for years."

On 6/15/21 at 12:40pm, V7 Registered Nurse/RN stated "I worked on 6/7/21 and was told (R1) was having pain to her right knee by (R1's) hospice nurse. I don't know what happened to (R1's) knee, but we did hoyer transfer her back to bed with three people and I assessed her. I gave her pain medication because her right knee was edematous, red and she was complaining of pain. I gave her Tylenol #3 and Morphine. (R1) does not bear any weight, and she was a two-person hoyer lift on 6/7/21."

On 6/15/21 at 12:45pm, V8 CNA stated "I worked 6/7/21 and I got (R1) ready for the day and left her in bed for breakfast per her request. I did not see her until later when the nurse wanted her put back to bed. When I came to help her back to bed, she was in the wheelchair with no hoyer pad under her and I thought that was odd because we leave the hoyer pads under residents when we transfer them because it is easier to transfer them again. I had the nurse help me put the hoyer pad under her so we could transfer her back to bed. It was me, the nurse (V7), and the hospice nurse in the room when we transferred her back to bed with the hoyer, she told the nurses she was in pain, and I left the room. I would have helped (V3) if I had known she needed help with (R1)."

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F 689	Continued From page 6 On 6/16/21 at 8:50am, V9- R1's family member stated "I noticed (R1's) leg was swollen when we had our visit that Monday (6/7/21). I was told a CNA transferred (R1) by herself and did not use two people and the lift which she has been using since she got to the nursing home."	F 689		