STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145883	A. BUILDING ______ B. WING ______	C 08/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIATT COUNTY NURSING HOME	**1111 N STATE ST MONTICELLO, IL 61856**

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F 000	INITIAL COMMENTS Facility Reported Incident of 8/13/21/IL137272	F 000		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the	F 656		8/27/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 09/10/2021

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 656	Continued From page 1 community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop care plans for residents who use a reclining chair. These failures have the potential to affect 19 of 19 residents (R1-R3, R5-R20) who use a power lift chair on the sample of 20. Findings include: The facility provided a list of residents who use a power lift chair at the facility. This list includes 18 residents R2-R3, R5-R20. R1's Incident Report dated 8/13/21 at 5:00am documents R1 was using a power lift chair at the time of R1's fall on 8/13/21. On 8/25/21 at 10:30am, V2, Director of Nursing stated R2-R3 and R5-R20 do not have care plans related to the use of power lift chairs and should have. V2 stated R1 had not had a care plan for the use of the power lift chair when R1 was using it.	F 656	Corrective actions which will be accomplished for resident found to have been affected by the deficient practice: " Facility failed to develop an assessment and update the care plans of residents in their safe use of electric lift chairs/recliners. The deficiency had the potential to effect 19 residents. " Facility developed on 8-26-21 the following policy and procedures, provided education training to staff on each. a. The policy regarding the Use and Safety of Electric Lift Chair/Recliner (Attachment 1) b. Electric Lift Chair/Recliner Assessment (Attachment 2) " R2-R20 were assessed for safety in the use of an electric lift chair/recliner which was completed 8/24/21 (Attachment 3) and their care plans updated to reflect the findings of these assessments on 8/27/21 (Attachment 4). Completed 8-27-21 How facility will identify other residents having potential to be affected by the same deficient practice: " Restorative staff will assess resident with electric lift chair/recliners upon	

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F 656	Continued From page 2	F 656	admission. Then quarterly, annually, and upon a significant change in condition. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and not recur. The facility must look at the existing system and determine if a change is necessary to correct the deficiency. If a system does not exist or if a revision to an existing system is necessary, then the facility must develop one. " Appropriate Staff members were in-serviced on the new policy and on how to complete the assessment. Completed 8-26-21 (Attachment 1) Completed 8-26-21 Quality Assurance plans to monitor facility performance to make sure that corrections achieved and permanent: " A member of the Quality Assurance Committee will audit for the completion of the Education and Safe use of Electric Lift Chairs/Recliners for those residents who have electric chairs/recliners to ensure they are completed timely and the corresponding care plan updates are complete. (Attachment 5) " D.O.N or designee will additionally audit documentation of Electric Lift chair/recliners assessments for compliance with policy and the completion of timely assessment.	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		8/27/21

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F 689	Continued From page 3 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 observation, interview and record review, the facility failed to assess residents for the ability to safely operate power lift reclining chairs and develop and implement policies and procedures related to the operation/use of these power lift chairs. These failures affect two of 20 residents (R1, R2) who use power lift chairs in the sample of 20. These failures resulted in R1's fall from the power lift reclining chair. R1 was found on the floor face down and was sent to the emergency room with a laceration requiring sutures and staples, severe neck pain and found to have acute fractures of C1/C2 cervical vertebrae. R1 admitted to Hospice upon return to the facility with a diagnosis of C1 fracture. Findings include: 1. R1's Face Sheet dated 8/24/21 document R1's diagnoses including Displaced Posterior Arch Fracture of First Cervical Vertebra, Displaced Fracture of Second Cervical Vertebra, Palliative Care with date of onset of 8/13/21. R1's Progress Notes dated 11/29/2020 document R1 has a history of Cerebrovascular Accident (CVA) with residual left arm Hemiplegia and left leg weakness. R1's Progress Notes dated 1/29/21 document R1	F 689	Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice. 1. R1s was effected by the deficient practice which resulted in actual harm, evidenced by the facilities failing to have an assessment in place to residents ability to safely operate an electric lift chair/recliner. The result was R1 falling from electric lift chair/recliner from which the resident received a fracture of the C1/C2 cervical vertebrae. 2. This deficiency had the potential to effect 19 other residents (R2-R20) who possessed and utilized their own electric lift chairs/recliners within the facility at the time of survey. 3. The facility conducted an audit of all electric chairs, developed a policy for The Education and Safe Use of Electric Lift Chairs/Recliners, develop and then conducted an assessment for their use with R2-R20. This was all completed on 8-24-21 before exit. (See attachment #1) 4. All nursing staff, charged with preforming the education and assessments, were in-serviced on supervision of residents using appropriate	

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has left side Hemiplegia.

R1's Brief Interview for Mental Status documents R1's Cognitive Status on 6/29/21 as moderately impaired.

R1's Incident Report dated 8/13/21 at 5:00am documents R1 was found on the floor of R1's room when an unidentified "Certified Nursing Assistant (CNA)" responded to R4, R1's roommate yelling for help. On arrival, V4, Registered Nurse (RN) noted R1 laying on R1's left side with the left side of R1's face to the floor and bleeding. R1 had a "Deep gash to left forehead with blood oozing out of it." V4 attempted to stop the bleeding by applying pressure but was unsuccessful and R1 was complaining of "severe neck pain." R1 stated R1 was attempting to raise R1's recliner but accidentally raised it too far and fell out of it. R1 also sustained a skin tear to the left forearm. This report also documents R1 is able to use the call light independently and last used the bedpan at 4:30am. R1 had been putting R1's right leg out of the bed and stated R1 needed to go somewhere so the staff placed R1 in R1's recliner with footrest up and remote in pocket of recliner. R4 had put the call light on and yelled out for assistance. R1 was noted face down on the floor and R1's recliner in an upright elevated position. R1 told V4, RN that R1 was leaning forward when using R1's recliner controller when R1 fell. R1 returned to the facility with a diagnosis of C1 and C2 spine with staples and sutures to the forehead and scalp. R1 was admitted to hospice on 8/13/21.

There is no documentation R1 was assessed for the ability to safely operate the power lift reclining

F 689

care plan interventions and a review of the new The Use and Safety of Electric Lift Chair/Recliner. (See attachment #2)

How the facility will identify other residents having the potential to be affected by the same deficient practice.
1. All residents in possession of an electric lift chair/recliner have the potential to be affected by the deficient practice.

The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. The facility must look at the existing system and determine if a change is necessary to correct the deficiency. If a system does not exist or if a revision to an existing system is necessary, then the facility must develop one.

1. All new admissions/readmissions will be assessed using the electric lift chair/recliner assessment. For all existing residents the assessment will be conducted quarterly, annually, and upon a significant change, to ensure continued safe use of these devices (See attachment #3)
2. Any staff who will administer the Education and Safe Use of Electric Lift Chairs/Recliners Assessment have been in-serviced 1:1 by the D.O.N. on its use. (See attachment # 2)

Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent.

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chair. There is no documentation R1 was provided education on how to operate the power lift reclining chair.

On 8/24/21 at 9:50am, V9, Consumer Call Center Representative for the lift chair company stated R1's power lift chair was discontinued in 2007. V9 stated the company would provide the company's basic manual for consumers. V9 stated R1 would have to be able to stand up and take steps independently to be safe to operate and properly use the power lift recliner. V9 stated R1 would have to be aware and have cognitive ability to safely operate the remote to the power lift chair.

R1's Care Plans dated 8/16/21 document R1 was "diagnosed with terminal illness: C1 fracture, and was admitted to Traditions Hospice on 8/13/21."

On 8/23/21 at 2:30pm, R1 was in lying in bed with eyes closed and use of accessory muscles were observed with breathing. There are two signs similar to each other on R1's wall directing staff to ensure R1's call light is attached to R1's clothing to help remind R1 to use it when R1 needs something. R1 had bruising to the left eye and a laceration extending towards top of head/scalp with a large bump and hematoma to the area and left side of R1's head.

On 8/23/21 at 2:50pm, V2, Director of Nursing (DON) stated the facility reviews and investigates the falls. V2 stated on 8/13/21, R1 was "confused" and told staff she wanted to go somewhere but didn't know where. R1 kept putting R1's right leg over the side of the bed and was restless so staff used a full mechanical lift to transfer R1 in to R1's power lift reclining chair. V2 stated V2 did not ask nor know if R1's call light

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1. The D.O.N or designee will conduct random monthly audits to ensure that all current residents with electric chairs/recliners are assessed according to the prescribe policy determining the date of mandatory review for existing residents. The DON or designee will then report their finds ot the Quality Assurance Committee (See attachment # 4)

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F 689	Continued From page 6	F 689		

had been attached to R1's clothing prior to staff leaving R1's room after transferring R1 in to the power lift reclining chair. V2 stated R1 has left side paralysis from a previous Cerebrovascular Accident (CVA) and is dependent on staff to transfer with a full mechanical lift. V2 was unaware if the chair had been evaluated or where the facility took R1's power lift reclining chair after R1's fall on 8/13/21. V2 stated V2 was unsure regarding other resident falls out of power lift chairs or if the facility had a policy and/or procedure on use of power lift chairs. V2 stated assessments for safety of use of power lift reclining chairs are in the Restorative Assessments for each resident.

The Basic Operation Manual is dated April 2021 and documents the intended use of this device is that of a device with motorized positioning control that is intended for medical purposes and that can be adjusted to various positions. The device is used to provide stability for patients and to alter postural positions. This device will provide lift assistance for people who have difficulty rising from a seated position to a standing position. This manual also documents, "WARNING! Do not attempt to stand up until you can stand safely, are steady on your feet, and can bear weight. We recommend the use of assistance aids and/or an attendant for enhanced stability."

The undated Guidelines for Nursing Homes, Ergonomics for the Prevention of Musculoskeletal Disorders documents, "OSHA (Occupational Safety and Health Administration) Description: Lift cushions and lift chairs. When to Use: Transferring residents who are weight-bearing and cooperative but need assistance when standing and ambulating. Can be used for

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independent residents who need an extra boost to stand. Points to Remember...Lift chairs are operated via a hand-held control that tilts forward slowly, raising the resident. Residents need to have physical and cognitive capacity to be able to operate lever or controls.

2. R2's Minimum Data Set (MDS) dated 6/24/21 documents R2 has a short term memory problem and has behaviors of inattention and altered level of consciousness.

R2's Minimum Data Set (MDS) dated 6/24/21 documents R2 requires supervision of one staff member for transfers.

R2's Incident Report dated 8/15/21 at 9:09am documents R2 was found on R2's buttocks in front of R2's lift reclining chair with the chair in the upward/raised position. R2's blanket was laying next to R2 on the floor. R2 stated R2 was trying to get up from R2's chair and slid on to R2's buttocks. This report documents V10, Licensed Practical Nurse (LPN) heard R2 yelling from R2's room and found R2 positioned on R2's buttocks in front of R2's chair. This report documents R2 is independent in R2's room using R2's rolling walker and that the Restorative program would assess resident abilities to reposition recliner correctly.

R2's Progress Notes dated 8/16/21 document R2 was "in-serviced" on the proper ways to operate R2's lift chair. R2 stated R2 knows how to operate it but R2 had pushed the wrong button. There is no further explanation regarding what button R2 was trying to push or what "ways" were included in R2's education related to operating the lift chair. There is no documentation the

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F 689	Continued From page 8 manufacturer's manual was used to educate R2. There is no documentation prior to R2's fall that R2 had received education on safe operation/use of the power lift chair. On 8/24/21 at 9:24am, V1, Administrator stated the facility was unable to find an operation manual/guidelines for use of the power lift chairs that were in the facility being used by residents. V1 also stated the facility does not have a policy/procedure in place regarding assessing for resident's ability to operate the power lift chair safely or education for residents regarding power lift reclining chair use. On 8/24/21 at 9:50am, V9, Consumer Call Center Representative for the lift chair company stated the remote should not be placed in the seat when not in use and should be locked/disconnected when not in use. V9 stated the company would provide the company's basic manual for consumers. V9 stated R2 would have to be aware and have cognitive ability to safely operate the remote to the power lift chair. On 8/24/21 at 1:35pm, R2's power lift reclining chair was positioned up/elevated off the floor with the remote placed on the seat of the chair. On 8/25/21 at 3:00pm, V2, DON stated the root cause of R2's fall was R2's inability to safely operate the power recliner controller.	F 689		