STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146075	A. BUILDING _____ B. WING _____	C 06/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANITE NURSING & REHABILITATION	**3500 CENTURY DRIVE GRANITE CITY, IL 62040**

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F 000	INITIAL COMMENTS Incident Report Investigation to Incident of 5-12-16/IL86034	F 000		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and 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 follow proper techniques for mechanical lifts and pivot transfers according to their policy for 2 of 7 residents (R1 and R2) in a sample of 7. This failure resulted in R1 sustaining a fractured femur 5/14/16 and R2 who sustained a fractured hip 5/12/16 during improper transfers. Findings include: 1. The Minimum Data Set (MDS) dated 3/21/16 documents R1 to require extensive assist of one staff for transfers and to have long/short term memory loss. R1's Care Plan, dated April 2016, documents R1 requires transfers with one assist and a gait belt. The Facility's Injury of Unknown Origin Investigation report documents, on 5/14/16, at approximately 4:15 PM, R1 was "sitting at the	F 323		

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

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nurses station and complained of right leg pain and was rubbing his right upper leg." The report documents that upon assessment, R1's right upper leg was swollen with no bruising or redness noted. The report documents the physician was notified with an order for an X-ray was obtained.

R1's X-ray report, dated 5/14/16, documents a "Spiral fracture of the distal right femoral shaft with shortening, displacement and apex anterior angulation." R1's Nurse's Notes documented R1 was transferred to the hospital Emergency Room (ER) for evaluation and treatment. The website OrthoInfo, Femoral Shaft Fractures (Broken Thighbone,www.orthoinfo.aaos (American Academy of Orthopedic Surgeons).org documents a spiral fracture as "Fracture line encircles the shaft like the stripes on a candy cane. A twisting force to the thigh causes this type of fracture."

The facility's investigation documents R1 was last transferred by E3, Certified Nurse Aide (CNA) the afternoon of 5/14/16. A written statement from E3, dated 5/14/16, documents he told R1 he was "going to get him up on the side of the bed and grabbed (R1's) feet as he grabbed ahold the bed rail on the left and turned his body to sit up on the side of the bed as I turned his feet toward the floor." E3 documented R1 repeatedly cursed as was normal and then wrote "So I told him we were going to stand up and I wanted him to put his hands on wall like we always do. So I grabbed his hand with my other hand on the back of his pants to help give him a boost if needed but when counting to three trying to get him to stand his legs wouldn't lock out so I sat him back down. I said to him 'what's wrong with you still tired or something' and he just said (curse words) again."

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E3 continued to write "So I told him we gonna try this again on the count of 3 but this time he couldn't stand neither so I let him sit on the side of the bed again." E3 documented he asked R1 again if something was wrong and R1 did not reply. E3 documented "I figured he just had along day and was tired so I told him I'm gonna help you transfer to your wheelchair so I put my hands on his left and right hip counted to three and transferred him from the bed to his wheelchair." E3 documented R1 propelled himself down the hall with no complaints. There was nothing in the investigation documenting that E3 used a gait belt with R1 for the transfer or asked for additional assist since R1 seemed to require more than one assist at that time.

A written note by E6, Registered Nurse (RN), dated 5/14/16, documents "At around 4:15pm writer was in the hall preparing meds when she heard a loud noise behind her sounding like it came from room 219" (R1's room) and she immediately went into the room. E6 documented R1 was on the edge of the bed and when writer asked CNA what happened, E3 told E6 that R1 wouldn't stand. E6 documented E3 attempted to get R1 up again and two minutes later brought resident out of the room in his wheelchair. There is no evidence E6 attempted to assist E3 in transferring R1 or advised him to get additional assistance since he seemed to require it at that time.

On 6/14/16 at 12:55 pm, E3 stated that he was very familiar with R1 at the time of his fracture and that he had transferred him multiple times without any problems prior to that. E3 described the event as he had written it in his statement.

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E3 was asked if he used a gait belt during the transfer with R1 and stated "No, (R1) had no gait belt on, should have had one on him but I didn't." E3 stated R1 did not appear in any pain during the transfer.

A statement dated 5/14/16 written by E14, CNA documents she care for R1 during the day shift on 5/14/16 and had no difficulties or complaints during transferring him to and from bed throughout the day.

On 6/15/16 at 9:20 am, E14 stated R1 had no problems that day and she last transferred him to between 2:00pm and 2:15pm the afternoon of 5/14/16 with no difficulties. E14 stated she checked on R1 at 2:30 pm and he was asleep.

On 6/14/16 at 2:00 pm, E1, Administrator, stated the facility policy would be to use gait belts on all pivot transfers and that E3 had been inserviced on gait belt transfers regularly with one done just prior to the incident occurring. E1 provided Transfer training sheets including gait belt use that documents E3 was last trained on 3/23/16.

Disciplinary Notes dated 5/17/16 for E3 document "On 5/14/16 Employee failed to follow safety rules by failing to use a gait belt when transferring a resident."

On 6/15/16 at 9:00 am, E1 stated she interviewed E14, the CNA that transferred R1 to bed on 5/14/16 and that E14 stated she had no difficulty transferring R1 to bed and R1 had no complaints.

The facility's policy entitled "Transfer belts/gait belts" dated 4/14 documents it is the policy of the facility "to promote safety in transferring

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residents, a gait is utilized when deemed appropriate." Under procedure, it documents "1. A gait belt is used if indicated on care plan." and "3. The resident is transferred by grasping the secured gait belt to provide stability and balance during movement."

2. R2's MDS dated 3/28/16 documents he requires total assist of two staff for all transfers. R2's Care Plan, dated April 2016 documents R2 is at risk for falls due to impaired mobility and Multiple Sclerosis in part. The Interventions document R2 is to be transfer per mechanical lift and assist of two staff.

The Facility's Incident Report documents on 5/12/16 at 3:45 pm, R2 had a fall with a fractured hip. The Departmental Notes, dated 5/12/16 at 5:30 pm written by E7, RN document "Resident on floor in room. CNA stated resident slipped out of (mechanical lift) pad during transfer." Injuries described in this note documents "laceration noted to forehead abrasion to left elbow and left knee, resident is complaining of left hip pain." The note documents the physician was called and an order for a left hip X-ray was given with the X-ray done at 5:30 pm. The next entry into the Departmental Notes is at 8:00 pm and documents "Results of L (left) hip x-ray shows nondisplaced L hip fx (fracture) results called to the MD (Medical Doctor)."

E4's, CNA, written statement documents that on 5/12/16, there were two aides on the hall and it was about supper time. E4 documented R2 was a "2 man" mechanical lift. E4 documented the other CNA was on break and she "preceded to get him up myself. When I got him in air and was almost to his chair he then started to slide out

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F 323	Continued From page 5 sling hitting the floor." On 6/14/16 at 1:25 pm, E1 stated in investigating the incident, it was determined E4 did not hook the mechanical lift sling correctly causing R2 to slide out of the sling when lifted. E1 also stated E4 was alone doing the lift and should have had another staff member to assist. E1 provided training records for E4 on mechanical lifts done on 3/23/16 and 5/4/16. Disciplinary notes dated 5/16/16 document that "Employee failed to follow pocket guide when using a (mechanical lift) while transferring a resident, which resulted in negative outcome." The facility's policy for Mechanical lifts dated 10/09 documents staff are to ensure four spring clips are in position before attempting to lift.	F 323		