

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

PRINTED: 02/26/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145247	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/25/2015
NAME OF PROVIDER OR SUPPLIER DOCTORS NURSING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 HAWTHORN ROAD SALEM, IL 62881		
(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	F 000			
F 323 SS=D	<p>Complaint #1550898/IL#75129 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, facility failed to safely transfer residents who required a mechanical lift for 2 of 2 residents (R1, R3) reviewed for transfers in the sample of 3.</p> <p>The findings include:</p> <p>On 2/25/15 at 7:00 A.M Z1 stated that on 2/14/14 R3 wasbeing transferred .in a Sit to Stand lift and the lift froze and R3 fell. Z1 stated that R3 had both shins scraped during the fall and the nurse bandaged both shins. On 02-25-2015 at 11:20 AM, E2 (Director of Nursing) stated that the Restorative Aides, Physical Therapy staff and the Certified Nursing Assistants determine who is needs a mechanical lift for transfers and two people are required to transfer residents with any mechanical lift. On 02-25-2015 at 11:30 AM, E7 (Certified Nursing Assistant) stated that if the battery isn't charged, the Sit to Stand lift will stop or "freeze" during a transfer. E7 stated that she</p>	F 323			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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 323	<p>Continued From page 1</p> <p>always checks the lift before using it because they will stop working during a transfer and E7 also stated that the lift has an emergency release button that can be used to lower a resident if the battery is dead. On 02-25-2015 at 12:30 PM, E4 (Certified Nursing Assistant/CNA) verified that she was the CNA that transferred R3 on 02-14-2015. E4 stated that she had R3 secured in the Sit to Stand lift with the waist belt and transferred R3 from her recliner to the commode with no problems, but when E4 had R3 over her recliner, ready to lower her into the chair, the Sit to Stand lift froze. E4 stated that R3 took the left strap off of the lift and when R3 did that R3 started to fall. E4 stated that she was doing the transfer by herself and without a gait belt, and when R3 fell, E4 grabbed her pants to keep R3 from falling, but R3 was lowered to the floor and scraped her shins on the Sit to Stand lift and needed to have it bandaged.</p> <p>R3's Nurses Notes stated that on 02-14-2015 at 8:45 PM, R3 was being transferred with the Sit to Stand lift and it froze during the transfer and R3 began to slip out , so the CNA lowered R3 to the floor. R3's Nurses Notes stated that R3's shins were scraped on the Sit to Stand lift and R3 had a skin tear to the right shin that wasn't deep, but required Steri Strips. R3's Fall Risk Evaluation dated 12-16-2014 stated that R3 had a score of 16 and is high risk for falls. R3's undated Restorative Care Flow Record stated that R3 was to be toileted and transferred with the Sit to Stand lift.</p> <p>2.On 02-25-2015 at 1:00 PM, E5 (Certified Nursing Assistant) stated that on 02-02-2015 she was transferring R1 without assistance or a gait belt and did not use the Sit to stand lift on R1</p>	F 323			

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F 323	Continued From page 2 resulting in R1 falling onto the floor. R1's Nurses Notes document that on 02-02-2015 at 10:00 AM, R1 told E5 that she could stand and needed to use the bedpan. E5 attempted to assist R1 to stand without a gait belt or the use of the Sit to Stand lift and R1 scooted out of her wheel chair onto the floor without being injured. R1 was then lifted with a mechanical lift into her bed. The facility's undated policy on the "Sit to Stand Lift" and the undated policy on the "Hoyer Lift" stated under "Important Notes"; This is always 2 person assist, Nurses and CNAs who have been trained on this procedure.	F 323			