STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145945	A. BUILDING _____ B. WING _____	C 06/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IMBODEN CREEK LIVING CENTER	180 WEST IMBODEN DECATUR, IL 62521

(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=G	Complaint Investigation #1462434/IL-70161. 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 transfer R1 following the plan of care to prevent injury for one out of three residents reviewed in a sample of three. R1 sustained a left tibia/fibia fracture. Findings include: R1 has a Brief Intermittent Medical score of 14 out of 15. Minimum Data Sheet dated 1/13/14 and coded an annual assessment states R1 requires extensive assistance of two staff for bed mobility, transfer, ambulation and toileting. Functional Assessment dated 1/13/14 states R1 is assistance of two staff for bed mobility, transfer, toileting and ambulation. On 6/10/14, at 11:30 am, R1 stated that R1 was being transferred by E4 (Certified Nursing Assistant/CNA) from the commode to wheelchair on 4/2/14 at approximately 5:00 pm. R1 stated that E4 and E6 (Certified Nursing Assistant/CNA)	F 323		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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IMBODEN CREEK LIVING CENTER	180 WEST IMBODEN DECATUR, IL 62521

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F 323	Continued From page 1	F 323		

transferred R1 to the commode but E6 left the bathroom after the transfer of R1 to assist answering other call lights and E6 stated would return to assist with the transfer off of the commode when E4 or R1 activated the call light.

On 6/10/14, at 11:30 am, R1 stated that R1 had completed using the bathroom and E4 (CNA) was in a hurry and wanted R1 to "get going to eat dinner". R1 stated that R1 felt too slow for E4. R1 stated that E4 assisted R1 from commode to standing position and R1 was holding onto grab bar attempting to transfer to wheelchair. R1 stated R1 lost balance and E4 fell into R1 and landed on R1's left leg. E4 then immediately sat R1 back on to the commode. R1 stated that E4 performed the transfer without assist of another staff member or a gait belt.

On 6/10/14, at 2:15 pm, E6 (CNA) stated that when E6 arrived to the bathroom approximately ten minutes later to assist with transfer from commode back to wheelchair, R1 already had trousers up. E6 questioned why R1 was sitting on the commode with trousers up. E6 stated that E4 (CNA) told E6 that E4 tried to transfer by self. E6 stated that R1 complained of left ankle pain at that time. E4 and E6 completed the transfer from commode to wheelchair at that time.

Nursing note dated 4/2/14, at 5:00 pm, states that R1 was being transferred from toilet to wheelchair and twisted left ankle. X-ray report dated 4/2/14 documents findings as oblique fracture involving distal fibula and a fracture of the distal tibia.

Hospital History & Physical dated 4/7/14 documents R1 was transferred and admitted to hospital on 4/2/14 with left tibia/fibia fracture

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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IMBODEN CREEK LIVING CENTER	**180 WEST IMBODEN DECATUR, IL 62521**

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F 323	Continued From page 2 requiring surgery. On 6/10/14, at 12:00 pm, Z2 (Physical Therapist) stated the R1 was not on therapy but was in a restorative program and that Z2 stated that R1 required assist of two staff due to inconsistency on functional abilities. On 6/10/14, at 1:50 pm, E3 (Director of Nursing/DON) stated that R1 did not experience a fall but R1's injury occurred during the transfer with E4. E3 stated that E3's recommendation would have been a two person transfer because of inconsistencies from day-to-day. E3 stated R1 is "not always the same" and assessment has been verified to always require two staff during transfers. Safe Resident Handling Policy effective July 2010 states, "The method for transferring, repositioning and mobilizing individual residents will be communicated to the nursing and care staff by ensuring this information is included in the residents care plan as well as on the care tool (Matrix) that guides the staff with resident care." The Policy also states, "Gait belts are to be used on anyone that is not independent."	F 323		