STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145697	A. BUILDING _____ B. WING _____	C 12/07/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOX COUNTY NURSING HOME	**800 NORTH MARKET STREET KNOXVILLE, IL 61448**

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F9999	FINAL OBSERVATIONS LICENSURE FINDINGS 300.1210a) 300.1210b)4 300.2420j) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 4) Personal care shall be provided on a 24-hour, seven day a week basis. Section 300.2420 Equipment and Supplies j) There shall be a sufficient quantity of resident care equipment of satisfactory design and in good condition to carry out established resident care procedures. This shall include at a minimum the following: wheelchairs with brakes, walkers,	F9999		

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F9999	Continued From page 6 metal bedside rails, bedpans, urinals, emesis basins, wash basins, footstools, metal commodes, over the lap tables, foot cradles, footboards, under the mattress bed boards, trapeze frames, transfer boards, parallel bars and reciprocal pulleys. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. Based on observation, interview and record review, the facility failed to implement procedures to ensure the integrity of mesh type slings used for mechanical lift transfers. The facility failed to revise policies and procedures for checking slings for defects prior to use; failed to ensure that all staff responsible for use of the mechanical lift were in-serviced on the need to check slings for defects; and failed to remove an additional defective sling after 1 of 11 residents, transferred via the mechanical lift using the mesh type sling, fell during transfer when the sling ripped apart (R1). R1 fell to the floor, hitting her head on the leg of the mechanical lift and her back on the floor. R1 sustained an abrasion to her right upper back. Incident report dated 11/4/05 indicated that an 80 year old female resident (R1) fell to the floor 11: 10 AM on 11/3/05 during a mechanical lift transfer with 2 nurse aides when the lift sling tore where the metal lift bars slide into the sling. The report stated that R1 sustained an abrasion to the right upper back. It also indicated that R1 was not interviewable to convey if she was in pain	F9999		

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F9999	Continued From page 7	F9999		

anywhere, so her physician ordered that she be sent to the hospital promptly for evaluation and radiologic examination. The hospital evaluation found R1 to be free of any fractures or significant injuries .

Interview with E2 (Director of Nursing) at 9:30 AM on 12/2/05 indicated that after the incident, she did person to person inservice with nursing staff present on the day of the incident. E2 stated that she had no written documentation of what was discussed with staff or which staff she in-serviced .

Interview with E9 (nurse aide) at 11:40 AM on 12/2/05 indicated that on the morning of 11/3/05, she and E8 (nurse aide) were transferring R1 in her room from the bed to a chair. E9 stated that the lift sling ripped as the lift was being turned toward the chair. R1 fell out of the sling with her head hitting the lift's lower metal leg and her back hitting the floor. E9 stated: "We usually don't check the sling, this is the first time this has happened." E9 said that she had not been instructed on inspecting lift slings prior to using them, although she would not use one if it had a big hole in it. E9 further stated that she was not aware of any lift in-services held after the incident .

Interview with E8 at 10:35 AM on 12/5/05 confirmed the details of the incident, as previously reported by E9. E8 stated that she had looked at that lift sling before it was placed under R1 prior to lifting, and "did not notice anything." E 8 said that that same sling was used the shift before with no problems. E8 also stated that she did not remember receiving any instructions

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F9999	Continued From page 8	F9999		

about inspecting lift slings prior to their use during their annual "education day" when they get refresher training on mechanical lifting. Additional interview with E8 at 9:30 AM 12/7/05 indicated that she received no in-servicing on lift sling inspection after the incident.

Interview with E2 (Director of Nursing) at 9:30 AM on 12/2/05 indicated that prior to this lift sling incident, the unwritten policy has been that laundry personnel were to inspect the slings for defects before sending them back to the floors. Nurse aides were to also check the slings before using them to lift residents. E2 stated that since the incident with R1, E5 (Medical Purchasing Clerk) is also required to inspect lift slings for defects, on a monthly basis. E2 also stated that the facility written policy on the use of mechanical lift equipment did not address inspection of lift slings before use or staff responsible for the task, nor was the policy amended to address this precautionary procedure after the incident of 11/3 /05.

Interview with E10 and E11 (nurse aides) at 2 PM and 1:50 PM, respectively, on 12/2/05 indicated that neither aide had received any lift sling safety in-servicing in the past month. E11 stated that she was on vacation for the first 2 weeks of November, and did not know that there had been a lift accident involving a torn sling at the facility.

The facility policy on using mechanical lifts, entitled: Lifting Machine, Using a Portable, provided basic instructions on using the lift and slings but contained no instructions regarding inspection of the lift slings prior to use or staff responsible for such. This was confirmed by

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F9999	Continued From page 9 interview with E2 (Director of Nursing) at 9:30 AM on 12/2/05. According to a list provided by E2 on 12/2/05, there are currently 21 residents transferred via mechanical lift. Eleven of these residents (R1 to R11) are transferred with the mechanical lift using the same type of open mesh sling which tore, causing the incident with R1. An inspection conducted with E5 and E2 of all available facility mechanical lifting slings/pads of different types and manufacturers, either in use or available for use, at approximately 10:30 AM 12/2/05, produced a count of 13 open mesh slings. One of the 13 mesh slings was noted to have a half-dollar sized hole in the mesh. None of the slings were coded in any way to distinguish one from the other for identification and inspection purposes. E5 confirmed by interview at approximately 10:30 AM on 12/2/05 that the facility had no such system in place for sling identification.	F9999		