STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145771	A. BUILDING _____ B. WING _____	C 02/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER BLUFF NURSING HOME	**4401 NORTH MAIN STREET ROCKFORD, IL 61103**

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F 323	Continued From page 6 resident up. Our bodies tend to expand when we sit. We also checked all the slings and replaced the ones with frayed ends." On 2/9/12 at 11:25 AM, Z3 (R3's wife) stated, "When I came into the room his left arm was up in the air and his right side was on the floor. There was nothing different about his behavior that day. He didn't appear nervous or shaky. He fell in the shower before this - he slid down because he was wet. If the belt is on right, he could let go and the belt should still hold him up. I think the belt was not fastened or not fastened tight enough. He usually holds on pretty good." On 2/9/12 at 10:25 AM, Z1 (Agency LPN) stated that she did not recall the incident. The facility policy entitles (Company Name): Lifts and Stands dated 12/16/99 states, "Fasten safety strap around patient to secure resident in harness."	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1210b)5) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a	F9999		

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F9999	Continued From page 7 Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall 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 resident care plan. 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. Restorative measures shall include, at a minimum, the following procedures: 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:	F9999		

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6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements were not met as evidenced by:

Based on observation, interview and record review the facility failed to ensure that a resident's feet were positioned on the floor during a transfer in a manner to prevent injury. The facility failed to ensure that the stand-lift belt was securely fastened around a resident's waist prior to transferring the resident from the toilet to the wheelchair and failed to ensure that a gait belt was used when transferring a resident from the toilet to the wheelchair. These failures resulted in R1 sustaining a fractured right tibia and a fractured right ankle which required surgical intervention on 2/1/2012.

This applies to 3 of 3 residents (R1,R2,R3)reviewed for transfers in a sample of 3.

The findings include:

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The Minimum Data Set of 12/12/11 shows that R1 has a diagnosis of Heart Failure.

The hospital Inpatient History and Physical Note dated 2/2/12 states, "(R1) is oriented to person, place and time."

The facility Incident report dated 2/1/12 states, "(R1) complains of pain in right ankle. Noted blue bruising on lower leg above ankle."

On 2/8/12 at 4:00 PM E3 (LPN) stated, " About 1:45 PM, E4 (CNA) said (R1) complained of ankle pain. I thought it was her left ankle. I went down to the room a little later and she was quiet in the bed so I did not assess her. Then about 2:45 PM, the family was there and they said she complained of ankle pain. I looked at it and her ankle was bruised. No deformity but she was screaming when it was touched and she said it hurt. (R1) kept saying she fell. E4 said she didn't fall. (E4) said (R1) started to complain that it hurt when she put her to bed."

On 2/9/12 at 9:00 AM E4 stated," We were short (staffed) that day. R1 was a shower -I did that in the morning- she did okay. Brought her back from lunch, took her to the bathroom- went potty, then transferred to bed with a gait belt. I went in the room about an hour later and (R1) told us her ankle hurt. I told the nurse and the nurse told me that (R1) always complains of ankle pain. She wasn't screaming or crying. I didn't notice any problems during the transfer. Didn't notice any bruising or deformities."

An undated written statement from E4 states, "On

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Wed. February 1, 2012 I was pulled to Blue Jay to work on 1 hall with (CNA). The daily ADL's were performed with out incident. Transfers were performed accordingly to assignment sheet. After breakfast/lunch resident without complaints. Approximately 1:30 PM resident complained of ankle pain nurse was notified also reported in shift report notebook, also used gait belt. Around 12:30, after lunch took resident to bathroom and transfer was performed with gait belt. Then resident was put to bed with no complaint."

A written statement from E5 (CNA) dated 2/10/12 states, "(R1) said she was in a lot of pain. I looked at her leg and there was a new bruise on her right shin. I took her shoe and sock off, slid my hand under her ankle and picked her foot up. It popped three times in my hand. I slid my hand under her shin and it popped again. I put the leg down..... I left the room and went to talk to E3, the day nurse. I told her that I think (R1's) foot is broke. I also told her that her foot popped three times when I picked it up. E3 went down to look at her foot and said it doesn't look good.... I went back later to check on (R1) and ask her what happened. (R1) told me she fell on the floor and the girl was on the floor with her. (R1) said she didn't remember exactly what happened but their feet were tangled up and she tried to get up but her foot was too sore."

A written statement from E6 (RN- Unit Coordinator) dated 2/15/12 states, "When (E5) asked to clarify "popping". She describes it as if bones were moving."

The Nurse's Note(NN) dated 2/1/12 at 3:20 PM states, "(R1) crying out, complains of pain in right

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ankle. Noted blue bruising to lower leg (above) ankle. No edema. Screamed when touched. Family at bedside.
The NN at 4:30 PM state,"Out to (hospital) for x-ray." The NN at 9:00 PM, "Admit to (hospital) with diagnosis of fractured right ankle."

The Hospital Emergency Department Notes dated 2/1/12 state, "Pt from (Facility Name). Pt was being transferred by staff and staff member fell onto patient around 12:30 this afternoon. Patient complains of right ankle pain. Bruising and swelling noted to the area."

The Hospital X-ray dated 2/1/12 states, "Distal tibia oblique diaphysis fracture with 5 mm lateral displacement.... The distal most fibula near lateral malleolus nondisplaced fracture."

On 2/9/12 at 10:00 AM, Z2 (R1's Grandson and Power of Attorney) stated, "The facility said she might have done it while going to the bathroom. (R1) said she fell and someone fell on top of her. When my mother walked in (R1) was laying there in pain." Z2 was asked if the Orthopedic Surgeon gave any explanation of how this injury could have occurred. Z2 stated, "No, he just said, 'I guess CSI will have to solve that one.'" Z2 was asked to describe R1's cognitive status. Z2 stated, "I wish I could say she is crazy and doesn't know what she is talking about, but that is not the case. When something is bothering her usually there is some basis for it. She is not confused and would not make things up. She doesn't hallucinate. If she says she fell, she probably did."

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2. The Physician's Order Sheet dated 12/2011 shows that R2 has diagnoses including Diabetes, History of Cerebrovascular Accident, Left Sided Weakness and Renal Failure.

The (Nursing Home) Incident Report dated 12/4/11 states, "(R2) was being transferred off the toilet, missed wheelchair and fell on to floor on left side rolled over and onto face hitting nose on door frame." The back of this same form states, "Agency CNA was not using a gait belt." and "Gait belt to be used for all transfers."

On 2/9/12 at 8:10 AM, E2 (DON) stated, "R2 had been losing control of her life and could be difficult at times. At times she did not want to use the gait belt. So this CNA was not aware that she should have put the gait belt on R2."

On 2/9/12 at 9:00 AM, E2 was asked to provide a copy of the facility's gait belt policy. E2 stated that the facility did not have a gait belt policy but provided a copy of a memo that is posted at each nurse's station. The memo says, "Whenever you assist a resident during a transfer you must use a gait belt. This includes stand by assist, 1 assist, 2 assist and contact guard. If seen not using a gait belt it will be considered an illegal transfer and you will be disciplined."

On 2/9/12 at 8:50 AM, E2 stated, "You can monitor staff but what goes on behind closed doors, you never know."

3. The Physician's Order Sheet dated 2/2012 shows that R3 has diagnoses including Chronic Obstructive Pulmonary Disease and Diabetes

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Mellitus.

The Facility Incident Report dated 12/10/11 states, "CNA was getting resident up with stand lift and he started slipping out of belt. CNA eased him to the floor. Resident is a right (BKA) below the knee amputation. The back of this same form states, "Needs to make sure belt is on properly."

On 2/9/12 at 8:30 AM E7 (CNA) stated, "I took (R3) to the bathroom. he seemed a little irritated when I put him in the stand. His leg started to tremble. He started to wiggle then he put his arms up and he slipped through the belt.. I am not his usual CNA but I checked to make sure it was okay to use the stand. I lifted him and he got agitated. I tried to turn the stand and he started coming out of it. I grabbed the back of his pants. He looked shocked and so was I."

On 2/9/12 at 10:30 AM, E8(CNA) was observed as she transferred R3 from his wheelchair to the toilet using the stand lift. R3 held on tightly to the grab bars of the stand lift and used a significant amount of upper body strength to hold himself up on the lift. E8 stated, "I have never had any trouble with him. If they had trouble before it must be because they didn't tighten the belt enough. Never been anxious or nervous with me. "

On 2/9/12 at 10:30 AM, R3 stated, "I have slipped out of the lift twice. The first time was in the shower. I was all full of body wash. The the second time, I don't know- I just slipped out. My right shoulder still hurts from the second time. I am never nervous or fearful in the sling. I have never been afraid of any CNA. I only have 1 leg so I have to use a lot of upper body strength to

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F9999	Continued From page 14 hold myself up." On 2/9/12 at 8:45 AM, E9 (RN) stated, "The agency nurse said the belt was loose on the sling. E7 said it was not. She thought it was from him doing a lot of wiggling. We did an inservice with all the CNAs and I noticed that some of the CNAs give the belt an extra little tug when they raise the resident up. Our bodies tend to expand when we sit. We also checked all the slings and replaced the ones with frayed ends." On 2/9/12 at 11:25 AM, Z3 (R3's wife) stated, "When I came into the room his left arm was up in the air and his right side was on the floor. There was nothing different about his behavior that day. He didn't appear nervous or shaky. He fell in the shower before this - he slid down because he was wet. If the belt is on right, he could let go and the belt should still hold him up. I think the belt was not fastened or not fastened tight enough. He usually holds on pretty good." On 2/9/12 at 10:25 AM, Z1 (Agency LPN) stated that she did not recall the incident. The facility policy entitles (Company Name): Lifts and Stands dated 12/16/99 states, "Fasten safety strap around patient to secure resident in harness." (B)	F9999		