

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

PRINTED: 01/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145515	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/13/2012
NAME OF PROVIDER OR SUPPLIER FREEBURG CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 746 URBANNA DRIVE FREEBURG, IL 62243		
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F 323	Continued From page 7	F 323			
F9999	<p>FINAL OBSERVATIONS</p> <p>LICENSURE VIOLATIONS</p> <p>300.1210b) 300.1210d)6) 300.2420j) 300.3240a)</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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.</p> <p>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:</p> <p>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</p>	F9999			

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F9999	<p>Continued From page 8 and assistance to prevent accidents.</p> <p>Section 300.2420 Equipment and Supplies</p> <p>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, 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.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)</p> <p>These requirements were not met as evidenced by:</p> <p>Based on observation, record review, and interview, the facility failed to provide a safe transfer for one of three residents (R2) reviewed for mechanical lift transfers in the sample of 3. This failure resulted in R2 falling out of the mechanical lift sling / pad during a transfer, and was hospitalized with a diagnoses of Multiple Pelvic Fractures and Subdural Hematoma.</p> <p>Findings include:</p> <p>On 8/30/12, at 1:00 PM, the facility incident report dated 8/25/12, 5:15 PM, was reviewed. The</p>	F9999			

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F9999	<p>Continued From page 9</p> <p>report documented E4 and E5, Certified Nurses Aides (CNA), were using a electronic mechanical lift to transfer R2 from her bed to a geriatric chair. During the transfer R2 fell from the elevated lift the floor, landing on top of the feet of the lift.</p> <p>E6, Licensed Practical Nurse (LPN), documented in the incident report, that she saw and heard R2 fall from the lift, ran to check her, and called 911. In a nurses note dated 8/25/12, 5:15 PM, E6, documented "the hoyer was in a high position, roughly 3 to 4 feet in the air and R2's back had landed on the feet of the hoyer."</p> <p>A written statement by E4, dated 8/25/12 at 5:15 PM, documented E4 had hooked up the lift pad to the mechanical lift, and then called E5 for assistance. E4 and E5 had lifted R2 off her bed, and as they were moving through the door of her room, R2's pad came undone and she fell to the floor, landing on top of the lift legs.</p> <p>A written statement by E5, dated 8/25/12 at 5:15 PM, documented E5 came to assist E4 to move R2. R2 was already hooked up to the lift and E5 was operating the lift / raising R2 up and down. E5 documents she did not notice anything out of order as they worked, but "all of a sudden R2 just dropped to the ground, we made it from the bed to the doorway."</p> <p>On 8/30/12 at 1:45 PM, an observation of the lift involved in R2's fall was done with E4, and E7, Maintenance Supervisor. E7 stated that he found nothing wrong with the lift mechanisms, the electronics of the lift, the swivel bar or hooks of the lift. During the observation of the lift, it was observed that there were three hooks on each</p>	F9999			

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F9999	<p>Continued From page 10</p> <p>end of the swivel bar (six total hooks) to use for hanging the lift sling / pad. Near the end / opening of each hook were two small holes. 5 of the hooks had empty holes, 1 hook had a small rectangular white metal ring / safety latch. When the latch was in the down position, it covered the opening of the hook and would prevent the sling from sliding backwards off of the hook. E4, stated that she could not remember seeing the latches on the hooks on 8/25/12 when she moved R2. E7 stated "sometime during the last year, the latches had come loose with use and fallen off the hooks. The CNA's had told me the previous Administrator said not to replace them." E7 stated he had not been asked to replace the latches prior to this incident.</p> <p>On 8/30/12 at 1:45 PM, in an interview with E4, she stated, "R2 was in bed, I put the lift pad on R2 and attached it to the lift. I called E5 to come help me. When we started lifting her I did not stop to check the sling / pad to be sure it was still in place on the hooks before moving R2 off of the bed. The part of the sling / pad that came off of the hooks was by R2's left leg. I guess it just slid off the hook, and she fell out of the sling about 3 or 4 feet to the floor. I didn't think she hit her head."</p> <p>On 8/30/12 at 2:30 PM, the facility's Final Report of Fall, dated 8/29/12 was reviewed with E1, Administrator and E7. In the report E1, documents, "it is my conclusion that E4 failed to properly secure the sling loop to the lift, enabling the sling to slip off and cause R2 to fall." E1 stated "R4 was disciplined for not making sure the sling was secured properly. R4 was retrained on 8/27/12 on the proper use of the lift and sling.</p>	F9999			

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F9999	<p>Continued From page 11</p> <p>E1 provided a copy of the Mechanical Lift Performance Check list that documented E4 had been in-serviced. Additional documentation of in-service attendance was reviewed for the remaining facility staff attending the mechanical lift in-services that were held on 8/26 and through 8/30/12. E7 stated "after R2's fall I checked all the mechanical lifts, there are three of them. I found that there were two lifts where the hooks were missing safety latches." The lift used to transfer R2 was pulled from use on 08/26/12 by E2, Director of Nurses, DON, and the second lift found to not have the safety latches was removed from use on 8/27/12. New safety latches were ordered for the lifts on 8/27/12.</p> <p>A review of the Owner / Operator Manual for Electric Portable Patient Lift, Reliant 450, documents on Page 20, is a picture of the lift and sway bar with 6 hooks, and all hooks have safety latches on the ends.</p> <p>The Owner Manual documents: Safety / Page 9, Using the Sling /Warning - Be sure to check the sling attachments each time the sling is removed and replaced, to ensure that it is properly attached before the patient is removed from a stationary object (bed, chair, commode). Safety / Page 9, Lifting the Patient / Warning - When elevated off the surface of the stationary object, and before moving the patient, check again to make sure that the sling is properly connected to the hooks of the swivel bar. Section 7 - page 35, Maintenance, Check the swivel bar sling hooks for wear or deflection, initially, and monthly. Page 36, Detecting Wear or Damage - Replace any defective parts immediately and ensure that the lift is not used until repairs are made.</p>	F9999			

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F9999	<p>Continued From page 12</p> <p>On 9/4/12 at 9:00 AM, R2 was observed in her bed at a local hospital, with Z1, Registered Nurse. R2 did not wake when spoken to. Z1 stated R2 was not responsive and had no active movements. On the left side of her head R2 had a 2 inch by 1 inch fading dark bruise and raised area behind her left ear, a large dark purple / blue bruise from the left under arm into the chest, a lighter dark purple bruise under the left scapula, and multiple dark purple and blue fading bruises down the length of her left arm, elbow and fore arm. Z1 stated these bruises were from the time of R2's admission. Z1 stated R2 did have other bruising on her right extremities, but Z1 could not confirm this was from prior to admission.</p> <p>On 9/4/12 at 9:40 AM, Z2, Physician / Hospitalist, stated "I saw R2 upon admission, and R2's current condition has not improved since. R2 did have a urinary tract infection that had been treated, but this did not contribute to R2's current state. R2's fall has caused her to be in this condition, no other illness is causing this decline."</p> <p>A review of R2's hospital CT-Scan (computerized tomography scan) dated 8/25/12, 19:15 (7:15 PM) documents, Findings: There is a small left parietal and temporal lobe subdural hematoma measuring 4.7 x 0.5 cm in the greatest AP and Transverse Dimensions. A Left Parietal Scalp Hematoma is seen. A CT-Scan done on 8/25/12 at 23:25 (11:25 PM) documents, Findings: This exam shows increased extension and thickening of an acute left temporal, parietal and occipital hematoma which measures 7 MM in greatest thickness.</p>	F9999			

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F9999	<p>Continued From page 13</p> <p>A review of R2's hospital CT-Scan of the Pelvis dated 8/25/12, documents, Findings: Nondisplaced fractures of Left Superior Pubic Ramus, Left Ischium, and Left Sacra Ala are seen.</p> <p>On 9/4/12 at 2:00 PM, in an interview with Z3, Manufacturer Legal Representative, he stated "the latch at the end of the lift hooks is an additional safety feature to ensure the sling / lift pad is properly in place. Sometimes the latches may fall off from use, but they should be immediately replaced, so the sling does not inadvertently slide off the hook. Sometimes people find them inconvenient, but they should not be removed. The facility can and should call us at any time they have questions or concerns about the lift."</p> <p>On 9/5/12 at 10:00 AM, in an interview with E7, he stated " over the past years some of the latches fell off during use, and some were removed by the CNA's. The latches were not replaced because the previous Administrator told the CNA's that they didn't have to have the latches on the lift. I was not part of that conversation, but the CNA's told me this. I checked the lift each month, but did not replace the latches." E7 stated this was at least a year ago, and thought E8 and E9, CNA's might have more information.</p> <p>On 9/5/12 at 10:30 AM, E8, LPN, and E9, CNA, were interviewed, and they stated, "the latches kept popping off, and we were told they didn't need to be replaced. I don't remember who told us this, but all the CNA's knew about it back in 2011. A lot of the staff who knew this don't work</p>	F9999			

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F9999	<p>Continued From page 14</p> <p>here any more. E8 stated that she "was told by other CNA's that the previous Administrator gave permission not to replace the latches". E8 did not know for sure when this was said.</p> <p>On 9/5/12 at 11:00 AM, in a telephone interview with E5, she stated "I was called by E4 to come and help move R2 to her wheel chair. R2 was already in the sling when I came to the room. I raised R2 off the bed and E4 and I moved her toward her chair. I did not check the sling after E4 attached it to the arm of the lift. While we had R2 in the air, the bottom of the sling came loose and R2 fell out. She landed across and on top of the legs of the lift."</p> <p>On 9/5/12 at 11:30 AM, E1, stated, "I just started working here in January, 2012. This is the first I have known that the mechanical lift had parts missing. I did not give anyone permission to remove the latches, and would have told E7 to replace them if I had known of the problem. At this time, the safety latches on all three mechanical lifts have been replaced. In my interviews with E4, she stated she did not check R2's lift prior to moving her off of her bed. I believe that the sling slid off of the hook and caused R2 to fall."</p> <p>On 9/5/12 at 12:00 PM, all three facility mechanical lifts were observed and found to have the safety latches in place.</p> <p>(A)</p>	F9999			