STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145681	A. BUILDING _____ B. WING _____	04/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PALOS HEIGHTS	13259 SOUTH CENTRAL AVENUE PALOS HEIGHTS, IL 60463

(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 441	Continued From page 20 The facility's signage sheet for contact and contact enteric precautions documents: personal protective equipment : put on in this order: wash hands, gown, mask (if needed), eye cover (if needed), gloves. Linen Management: bag linen in the patient's room. In Policy and Procedure "Clostridium Difficile Infection" revised 2/12 is documented "Isolation Precautions 5. Gowns should be worn if physical contact with the resident or the resident's environment is anticipated." In the facility "New Employee Orientation Infection Control" is documented "1. Contact Precautions Used when infection is transmitted by touch. Gloves if touching client's skin or surfaces in close proximity to the client. Gown if clothing will contact client or potentially contaminated environmental surface."	F 441		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATION: 300.610a) 300.610c)4) 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. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives	F9999		

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F9999	Continued From page 21 of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. c) The written policies shall include, at a minimum the following provisions: 4) A policy to identify, assess, and develop strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a resident. Section 300.1210 General Requirements for Nursing and Personal Care 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: 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 regulations were not met as evidenced by	F9999		

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F9999	Continued From page 22 the following: Based on interview and record review, the facility failed to ensure that safety precautions were implemented during a mechanical lift transfer involving one (R3) of four residents, reviewed for transfers from the sample of 24. This failure resulted in R3 sustaining a head laceration, a hospitalization, and nine sutures to the head. The facility also failed to assess for the use and safety of the specialty reclining wheelchair for two residents (R32, R19) from the sample reviewed for assistive devices and 12 residents (R3, R35, R40, R42-R50) in the supplemental sample Findings include: 1. R3 is a 93 year old female who was admitted to the facility on 6/9/09 with diagnoses that includes failure to thrive, dyspepsia, constipation, and gastro esophageal reflux disease. R3's client care guide dated 11/19/12 indicates that R3 requires the use of a total mechanical lift for transfers. R3's fall risk assessment dated 12/17/12 indicates that R3 was at risk for falls. An occurrence report dated 3/1/13 at 12:15 PM, indicates that R3 had a fall onto the floor during a transfer from the bed to the chair, by E13 (Certified Nurse Assistant) and E14 (Certified Nurse Assistant) and incurred a laceration to the left side of the back of the head and a bruise to the left side of the rib cage.	F9999		

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F9999	Continued From page 23 Nurse's note dated 3/1/13 at 2:51 PM, indicates that R3 slid out of a mechanical lift sling, hit her head on the floor, and incurred a 1 centimeter laceration to the back left side of the head that had a moderate amount of bleeding. The area was cleaned with normal saline and a pressure dressing was applied, there was no loss of consciousness, and the physician and a family member were notified. Physician order sheet dated 3/1/13, indicates an order to transfer R3 to a local hospital for evaluation of a head laceration. Nurse's note dated 3/1/13 at 11:00 PM, indicates that R3 returned from the local hospital at 5:30 PM, received 9 sutures to the back of the head. All computerized tomography (CAT) scans and x-rays were negative. Physician order sheet dated 3/1/13 for R3, also indicates an order to cleanse back of head suture line with normal saline until sutures dissolve one time a day and as needed. Review of R3's treatment record, indicates documentation that R3 received the ordered treatment from 3/1/13 to 3/18/13. On 4/3/13 at 1:32 PM, during an interview, E13 stated that E14 was assisting me with transferring R3 back to the chair from the bed. We were transferring her with the mechanical lift machine. Somehow when we transferred her from the bed to the chair, something came apart and she slid to the floor. She had a sore on her head from the	F9999		

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F9999	Continued From page 24	F9999		

fall and they sent her out to the hospital. E14 was holding the pad where her upper body was and I was guiding the machine. We train on the mechanical lift machine twice a year. We practice on each other. We were trained this year on the mechanical lift. I don't remember the date of training.

On 4/3/13 at 3:32 PM, during an interview, E14 stated that E13 came and asked me to spot her with R3. Spot means that when you move a patient, you need two people. E13 put the lift pad under R3 and lifted her up with the lift. I was by the chair and I was helping guide the lift. As she was turning R3 in the mechanical lift machine, somehow she just slipped out of the lift pad. I was trying to hold the chair and help guide the machine. My hands were not on the pad underneath the patient. My hands were over the latch on the back of the pad. She did have a laceration on the back of her head. I was trained on the mechanical lift. We were trained in January. They do training two to three times a year.

On 3/6/13, E2 (Assistant Administrator) presented an email to indicate that the mechanical lift machine will be inspected for proper working order dated 3/1/13 at 12:56 PM. Review of an email dated 3/1/13 at 1:51 PM, indicates that the mechanical lift machine was inspected and is in proper working order.

On 3/19/13 at 4:31 PM E2 and E3 (Director of Nursing) stated we do competency twice a year for staff on the mechanical lift, sit to stand machine, and gait belt training. They lift each other and review the policy.

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F9999	Continued From page 25 The facility's limited lift safe client movement program policy doesn't document procedures on how to secure the resident within the sling on the mechanical lift machine while transferring a resident from one surface to another. 2. The following residents use a specialty reclining wheelchair: R32, R35, R40, R42, R43, R44, R45, R46, R47, R48, R49 and R50. No assessment for use, monitoring or care plan was done for the use of these specialty reclining wheelchairs prior to survey. On 4/11/13 at 2:00pm E3 (Director of Nursing) stated hospice usually orders the specialty reclining wheelchair and its delivered to the facility. E3 also stated she was not sure if the the physical therapy department preforms an assessment for the use of these assistive devices. If so the documentation would be in the physical therapy notes. No assessments found for the use of these assistive devices. On 4/11/13 at 2:03pm E3 also stated was not aware if the residents are fitted for the use of this specialty reclining wheelchair. B	F9999		