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F 323	Continued From page 26 in-service and orientation for nursing employees. Initiated: 11/21/2013Responsible staff: DON	F 323		
F9999	FINAL OBSERVATIONS Statement of Licensure Violations 300.610a) 300.1010h) 300.1210b) 300.1210c) 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 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. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan	F9999		

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of care for the care or treatment of such accident, injury or change in condition at the time of notification.
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:
c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.
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 requirements were not met as evidenced by:

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Based on observation, record review and interviews, the facility failed to use two staff members to assist with a mechanical lift transfer as required by the resident ' s care plan and facility policy for one (R1) of five residents utilizing mechanical lifts for transfer. R1 was transferred using a sit-to-stand mechanical lift and slipped off the platform on two separate occasions, the second occurring two days after the first. This failure resulted in an immediate jeopardy. R1 sustained severe back pain and an overall decline in function.

Findings include:

The facility policy titled, " Limited Lift Resident Transfers " and revised 4/19/11, states, " Nursing staff will transfer residents according to their transfer status as assessed by therapy or neighborhood coordinator. 3. resident's transfer status will be posted in the resident's room on the inside foot board of their bed. Resident transfer status is to be checked before every transfer is initiated. Transfer is to be completed according to the resident transfer status. Transfer status will also be listed on the care plan and in the CNA(Certified Nurse Aide) instructions. If no transfer status is posted or if transfer status is uncertain in any way caregiver is to check with the nurse first, before initiating transfer. 12. This policy is to be followed at all times. Failure to adhere to the policy will result in disciplinary action by the criteria below unless the Administrator/DON deem the situation requires further immediate disciplinary action.

The facility policy, titled " Incident Reports " and

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F9999	Continued From page 29 revised 5/28/12, states, " Incident reports will be completed on residents when the following have occurred either in-house or off the campus: 1. Falls, witnessed or unwitnessed ...4. Any behavior, situation or injury with possible indicator of abuse, or anything out of the ordinary for the resident. PURPOSE: to document the details of the incident, to ascertain the root cause, and to prevent recurrence. PROCEDURE: 1. Complete incident report: Provide and accurate description of the incident along with any witnesses. Interview staff, residents, or any that may have knowledge of incident. Complete report thoroughly, with no missing info. Document thoroughly in the progress notes matching the incident report. Place resident on focus charting for at least three days. R1's MDS (Minimum Data Set) Assessment, dated 8/23/2013, documents R1 to be 96 years of age with diagnoses including Heart Failure, Dementia, Depression, and Hypertension. The MDS noted R1 at six feet two inches tall, 241 pounds, to be non-ambulatory, requiring extensive two plus person physical assist for bed mobility, dressing, bathing, toileting and transferring. R1's care plan, dated 8/25/13, documents R1's transfer status required a sit to stand device plus two-person assist. R1's care plan also includes the problem of pain due to Osteoarthritis in the knees, lower back and shoulders. There are no Nursing Notes in R1's medical record from 10/18/13 to 10/3/13. Nursing Note, written by E4 (RN/Registered Nurse) and dated 10-31-13 at 7:45 AM, states, "As (R1) was being transferred from sit to stand onto bed, his legs	F9999		

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slipped off lift. Assisted with staff times three to correct position of legs back onto lift to complete transfer. Resident assessed, no reddened areas noted to upper or lower back and legs. (R1) complain of lower back pain, scheduled pain meds administered with relief noted. (R1) said (R1) felt better after lying down. Will continue to monitor." The note states it is a late entry for 10-29-13.

The facility incident/investigation, dated 11/6/13, includes the following documentation by (E2/DON/Director of Nursing), "Talked with (E8/CNA) regarding episode on the 29th of October with (R1). At approx. 8-9 pm (R1) was in bathroom with (sit to stand mechanical lift). (R1) is a two-person assist. (E8) 'Did not look where (R1's) feet placement was' or know that (R1) was a two person assist. 'I (E8) did not look at the end of the bed.' When (E8) got (R1) to the center of the bed, (R1's) feet slipped off back of lift, leaving (R1) semi hanging on the lift and feet (toes) on the floor. (E8) immediately yelled for help, the two nurses (E4/RN and E5/LPN/Licensed Practical Nurse) assisted (E8) with helping (R1) into bed. (R1) had no injuries, but did complain of (R1's) underarms hurting. Slight redness noted but no skin abrasions. (R1) had no other pain at that time." On ---------------- -11/19/13 at 10:35 am, E2 confirmed that E8 was the only person interviewed by E2 regarding the incident involving R1 on 10-29-13.

At 1:50 pm on 11/13/13 E4 (RN/Registered Nurse) stated the following in regards to the 10/29/13 approximately 8:30 pm incident with (R1), "(E8/CNA) yelled my name from (R1's) room. I and (E5/LPN/Licensed Practical Nurse)

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went up the hall. (R1's) feet had slipped off and he was hanging by the handrails. (E5) and I got his feet back on while (E8) ran the lift. (R1's) care plan says two-person assist for transfer with the lift. The belt was still on and the straps were still connected. (R1) was complaining of back pain at that time. There should have been three-day focus charting for that incident. I noticed that I forgot to chart so I did that back note on the 31st for the 29th."

On 11/13/13 at 3 PM, E2 (DON/Director of Nursing) stated, "This is the room and the bed (R1) was using during the 10/29/13 transfer incident. The foot of the bed was marked transfer with two right here. (E8/CNA) didn't look here to see (R1) was a two-person transfer. (E8) hadn't worked with (R1) for a long time. They don't have to look at the care plan. They just have to look at the foot of the bed." The sticker that documented that R1 required the assistance of two people for the mechanical lift transfer remained on the footboard of the bed in the room once occupied by R1.

On 11/13/13 at 3:10 pm, E5 (LPN) stated, "I was going down the hall when I and (E4/RN) heard (E8/CNA) yell. We both went to find (R1) hanging off the lift with the belt up around under (R1's) armpits. We maneuvered his feet back on. One side at a time. There was a red mark under his left arm." The statement was in regards to the 10-29-13 incident involving R1.

On 11/13/13 at 3:18 PM, E8 (CNA) stated, "I took (R1) to the bathroom on the sit to stand lift and was coming back to the bed when his foot slipped off and continued to go on when the other foot started to go off, too. The nurses came to help

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F9999	Continued From page 32 as (R1) was hanging on the lift. The lift pad was under his armpits instead of around his waist. It was tight. (R1) was a one-person assist as far as I knew. The DON (E2) talked to me a couple of days later that (R1) was a two person. First time I worked with him in about a year. Yes, it is marked on the bed. The last time I was over there, he was a one person. I can look on the care plan system but some areas are restricted. CNA's pass that information on. Usually. That was the only night I worked there." Nursing Note in R1's medical record, dated 10-31-13 at 2:00 PM states, "Note: (R1) has continued to complain of low back pain. Had scheduled pain pills this /AM. Pain meds help, as long as (R1) doesn't move any. CNAs stood (R1) up with sit to stand, I ((E12/LPN/Licensed Practical Nurse) happened to walk into room during transfer with (R1) on sit to stand. (R1) standing very poor....Knees were buckled, feet with one on top of other, and arms with elbows pointing towards the ceiling. Talked with E20 (RN/Restorative) suggested we use (full mechanical) lift for transfers at this time. (E11/R1's Medical Doctor in a meeting) (Z2/E11's nurse) Will call back if (E11 available). " The note is signed by E12 (LPN). On 11/19/13 at 10:25 AM, E12 (LPN) stated, "They were standing (R1) up with the sit to stand and (R1) had no strength. (R1) couldn't tolerate it. His elbows were pointing at the ceiling, not holding on to the handles. His knees were buckled," in regards to the incident on 10-31-13. On 11/19/13 at 10:30 am, Z2 (E11/nurse at R1's Medical Doctor's office) stated, "I don't have any record of a call from the facility on the 29th.	F9999		

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Facility called here on 10/31/13 and left message that (R1) was having a lot of lower back pain. When I called back, they mentioned (R1) was on a sit-to-stand lift and R1 ' s feet had slipped off and jarred him, possibly hurting it then, and now is leaning to one side. Did not say when that happened. Is on Norco and Fentanyl patch. No calls about 10/29/13 that I know of. No. No mention of a second incident."

On 11/19/13 at 1:55 PM, E10/CNA reported the following in regards to the incident of 10/31/13 involving (R1): "(E13/CNA) and I were transferring (R1). I recall (R1) was hooked up fine but when we started to raise the sling (R1) started to slide. The sling slid up. We tried to tighten/shorten the strap and that is when the nurse stopped by. (R1) said, 'You're hurting my back.' I didn't know about any previous incident with the lift. I didn't notice where his feet were. But, I did see his elbows go up. I knew he (R1) wasn't holding on. (R1) was like, too weak to bear weight. Then, I guess his knees did buckle. He was dangling for a second until we got him set back down. That's when the nurse (E12/LPN) decided to change him to a (full mechanical lift)."

R1 ' s care plan includes no new interventions related to transfers on or after 10/29/13.

On 11/19/13 at 2:15 pm, E2 stated, "No, I don't have an investigation for the 10-31-13 incident involving R1, but I will make you one if you want me to."

R1's CNA notes document R1 was not transferred from his bed after 11/6/13 at 5:06 pm. After that date, R1 was only turned and

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F9999	Continued From page 34 repositioned in the bed. R1's Nursing Notes document the following: 10/31/13 at 3:25 am, (R1) refused shower due to lower back pain; 11/1/13 at 6:28 pm, (R1) didn't eat dinner after given 4 units of insulin, had poor appetite, stomach appeared distended; 11/3/13 at 1:54 pm, Urine is cloudy, greenish-gray, foul odor, with sediment present, start Levaquin 250 milligrams once daily times ten days; 11/4/13 at 2:45 am (R1) fidgety and restless, increased confusion, stated water's running out of the toilet onto the floor, explained to resident there wasn't any water on the floor; 11/4/13 at 11:02 am called to doctor about restlessness, continued wheezing and confusion, sweating, and distended abdomen; 11/4/13 2:47 pm Dr (doctor) orders for IV fluids; 11/4/13 at 3:16 pm vomited minimal amount; 11/4/13 at 3:40 pm increasing temperature and minimal vomiting; 11/6/13 at 3:03 am complain pain to back and legs, Morphine given; 11/7/13 at 6:51 pm resident placed on comfort care; 11/9/13 at 9:20 am atropine drops due to heavy secretions; 11/11/13 at 12:39 am (R1) expired. (B)	F9999		