STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008528	A. BUILDING: _____ B. WING _____	C 01/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAWNEE CHRISTIAN NURSING CTR	1901 13TH STREET HERRIN, IL 62948

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S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b)5) 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 which 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. 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	S9999		

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S9999	Continued From page 1 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. 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 Regulations were not met as evidenced by:	S9999		

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Based on record review, and interview, the facility failed to safely transfer from the bed to a wheeled chair 1 resident (R4) reviewed for safe transfer. This failure resulted in R4 sustaining comminuted fractures of the right distal fibular and tibial diaphyseal and fifth metatarsal head fracture requiring hospitalization and surgery to repair the fractures. The facility also failed to follow its own policy and procedure for transfers/gait belt use.

Findings include:

1. R4 a 92 year old woman was admitted to this facility on 12/16/2013 according to facility admission records of that date. R4's Physician Order Sheet dated 12/16/2013 lists her diagnoses to include; Chronic Kidney Disease, Congestive Heart Failure, Rhabdomyolysis, and Muscle Weakness. According to the facility's Incident/Accident log of 12/26/2013, R4 was transferred by E7 (Certified Nurse Assistant/CNA) from the bed to her wheeled chair, R4 sustained an injury to her right leg. Review of R4's record notes, the Minimum Data Set/MDS dated 12/23/2013 identifies R4 to require extensive assistance of two staff for transfers. R4's Care Plan with an initiation date of 12/16/2013 indicates a Focus of "requires ext. assist of 2 for all transfers, with an intervention to provide 2 assist with all transfers". The MDS Kardex Report (undated) notes transfers, extensive assistance, two person physical assist. Review of E7's Clinical Staff Orientation Checklist and Sign Off document fails to note date/time or signature of E7 for topics completed. Review of the facility training records titled Transfer and Reviewing CNA kardex dated 12/28/2013 notes by signature that E7 was in attendance and did receive this training, this training was provided after the incident of 12/26/2013. Review of facility

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policy/procedure titled Gait Belt, dated 5/26/2009 notes "gait belts are utilized on all residents requiring assistance with transfers".

During an interview on 1/15/2013 at 3:00 P.M. with E7, when asked about the incident on 12/26/2013 when R4 was injured, E7 stated, "I was working with another aide E8 (CNA) and she told me to go and get R4 up for dinner. I went to move her from the bed to the wheeled chair, not using a gait belt, I first moved her legs off the bed and put her feet on the floor, I used a bear hug to pivot her into the chair, as I pushed the chair back I noticed blood dripping onto the floor, I immediately called for help. I don't know how she got injured, I did not do anything wrong, I used the transfer technique I was taught by E8. She (R4) never yelled out in pain, I did not hear a pop. When asked if she knew that R4 required extensive assist of 2 person for all transfers E7 stated, "No one told me that, I never saw her care plan, and I was never shown how to read the CNA kardex." When asked about transfer training, E7 stated, "I received training during orientation but the first day of orientation I missed all the nursing stuff because of a family emergency. I had to leave work early that day." E7 stated, "After the incident on 12/26/2013 (Thursday), and after giving her statement to administration she was sent home and stayed off work the next day (Friday), adding she was off on Saturday and Sunday, and she was allowed to return to work the following Monday after being told the incident was unsubstantiated." E7 stated, "She began her employment at this facility on 12/3/2013."

On 1/15/2013 at 2:30 P.M. E8 (CNA) was interviewed regarding R4 and the incident on 12/26/2013. E8 stated, "She has worked at this

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facility 7 months prior to the incident of 12/26/2013. E8 stated, "Staff were getting residents up and ready for dinner, and she asked E7 to "get R4 ready for dinner". E8 denied asking E7 to get R4 up. Shortly afterwards she heard E7 yell for help and E8 responded. When E8 entered the room R4 was sitting in her chair in the middle of the floor, her foot was dangling, blood was on the floor and the bandage on her right leg was soaked in blood, there was no blood in the bed, there was no blood on the chair or wheels on the chair." E8 stated, "She called for the nurse and applied towels and pressure to control the bleeding. E8 stated, "The nurse responded and provided care to the leg and 911 was called. When the ambulance arrived R4 was taken to the local hospital. E8 stated, "She then asked E7 what happened, and E7 said, "I don't know what happened, I did not do anything to hurt her (R4)." When E8 was asked if she had trained E7 on transfers, E8 stated, "Yes, but only on the residents we had worked on together.

E9 (CNA Supervisor) was interviewed on 1/15/2013 at 1:00 P.M.. When asked about R4, and the incident of 12/26/2013, E9 stated, "He was working in another area of the building and was notified of the incident after it happened. E9 stated, "He asked E7 how the injury occurred, and E7 stated, "I don't know how it happened I did not do anything to hurt her."

E14 (CNA) was interviewed by telephone (this was her day off), on 1/15/2013 at 12:40 P.M. When asked about R4, and the incident of 12/26/2013, E14 denied working on that date stating "I was on vacation for 5 days". When asked about training E7 on transfers, E14 denied training E7 on transfers.

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S9999	Continued From page 5 Z1 (Physician) was interviewed by telephone at 2:00 P.M. on 1/15/2013 and was asked about possible causes for the injury to R4. Z1 stated, "She had reoccurring falls at home, I was told by the Hospitalist, that she was being transferred from the bed to the wheeled chair and I cannot say what caused the fractures. I don't know what happened, don't know if there was any abuse, there are new staff there and I hope they will be able to make sure everyone receives the care they deserve." (B)	S9999		