STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002141	A. BUILDING: _____ B. WING _____	10/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY HEALTH	RURAL ROUTE 1 BOX 14 GIFFORD, IL 61847

(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) COMPLETE DATE
S9999	Final Observations Statment of Licensure Violations: 300.610a) 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 300.1210 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.	S9999		

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S9999	Continued From page 1	S9999		

These requirements are not met as evidenced by:

Based on observation, interview, and record review the facility failed to implement and provide safe transfer as directed and wheelchair transport for five of nine residents (R8, R3, R12, R5, R13) reviewed for falls on the sample of 17. These failures contributed to a fall for R8 resulting in R8 sustaining a laceration requiring hospital treatment.

The findings include:

1. The Occurrence Report states on 6/5/14 at 4:20 AM, R8 was "dropped" by E13 (Certified Nursing Assistant/CNA) during transfer. The report states R8 sustained a 2.5 centimeter laceration to the left side of her scalp. The report also includes E13's statement that she transferred R8 without using the sit-to-stand mechanical lift.

The Investigation Report, signed by E1 (Administrator) on 6/9/14, states R8 was transferred by E13 using a stand-pivot transfer, without a stand lift. E13 pivoted R8, realized the chair was too far away, and lowered R8 to the ground. R8 then struck her head on the edge of the nightstand, sustaining a laceration to the top of her head.

Nurse's Note dated 6/5/14 at 4:40 PM states R8 was transferred to the hospital. Nurse's Note dated 6/5/14 at 10:50 AM states R8 returned from the hospital with six staples to her scalp.

On 10/15/14 at 12:50 PM, E2 (Director of Nurses) stated, at the time of the fall, R8 was to be

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transferred by sit-to-stand lift. E2 stated E13 knew that R8 was to be transferred using a sit-to-stand lift.

The facility's Resident Handling Policy states initial screenings are performed on all residents to assess transfer status. Resident transfer status will be tagged in the resident's rooms to inform the staff of the appropriate transfer to use.

2. On 10/14/14 at 11:07 am, E5 Activity Aid) pushed R3's wheel chair through the lobby into the dining room. R3 grimaced while she leaned forward as she held the onto the arms of the wheel chair. R3's feet were bent underneath the wheel chair seat and R3's toes dragged the floor.

On 10/14/14 at 11:12 am, E5 stated, "Sometimes she (R3) can keep her feet up and sometimes she can't. They don't really train us on what to do when the residents drag their feet, I just know we can't pull them backwards."

3. On 10/14/14 at 1:04 pm, E6, (CNA) pushed R12's wheel chair out of the dining room, through the lobby and down the hall. R12's feet drug under the wheel chair seat for the duration of the 75 foot transport.

On 10/14/14 at 1:08 pm, E6 stated "(R12) tends to drag her feet alot, it doesn't stop the wheel chair very often."

4. On 10/14/14 at 4:30 pm, E7 Housekeeper pushed R5's wheel chair at a fast pace down the hall, through the lobby and into the dining room, approximately 200 feet. R5's legs were extended with the heels of his shoes abruptly skipping on the tile floor.

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On 10/14/14 at 4:37 pm, E7 stated, "(R5) has a brain tumor so sometimes he can't help it and other times he drops his feet on purpose."

5. On 10/15/14 at 8:58 am, E8, Beautician/CNA, pushed R13's wheel chair from the dining room to the south hall corridor approximately 50 feet. R13 leaned forward with her feet knocking along the tile floor, stating, "Oh, oh, oh" during the transport.

On 10/15/14 at 9:04 am, E8 stated "sometimes she (R13) won't keep her feet up no matter how many times we remind her."

On 10/15/14 at 9: 15 am, E11, Physical Therapy Program Manager stated, "The residents should not be expected to hold their feet up for extended periods of time . . ."

The undated facility policy titled "Transport Procedure" states "If the resident becomes uncooperative, feet drop or drag you are to stop and get a licensed staff."

(B)