STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008973	A. BUILDING: _____ B. WING _____	C 01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESENCE ST JOSEPH CENTER	659 EAST JEFFERSON STREET FREEPORT, IL 61032

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S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b)5) 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 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	Attachment A Statement of Licensure Violations	

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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. 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. (A, B) (Section 2-107 of the Act) These Requirements are not met as evidenced by: Based on interview and record review the facility failed to transfer a resident (R1) in a safe manner. The facility failed to assess and provide safety measures for a resident at risk for falling. These failures resulted in R1 sustaining fractures	S9999		

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to both hips on 1/09/15.
This applies to 1 of 6 residents (R1) reviewed for transfers in the sample of 6.
The findings include:
On 1/09/15 at 3:45 PM, the nursing notes states, an alert and oriented R1 arrived at the facility after a seven day hospital stay. On 1/09/15 at 9:00 PM, R1 sustained bilateral hip fractures from a fall during a transfer within the facility. On 1/10/15 at 10:41 PM the local hospital weighed R1 at 299 pounds with diagnoses that include, Morbid obesity, Osteoarthritis, Chronic pain, Degenerative joint disease, and Disc disease. On 1/17/15 at 3:30 PM, E3 said because R1 was admitted at 4:00 PM and was sent to the local hospital at 9:00 PM she was not assessed by rehabilitation services, and did not have a Minimum Data Set (MDS) assessment.
On 1/17/15 at 7:00 PM, E1 (Administrator) said that R1 was admitted to the facility after rehabilitation services (Rehab) left for the day. The rehab people do the assessment of the resident ' s ability to stand, transfer, and walk. E1 ' s expectation of the medical staff in a late hour admission is to look at the hospital record, ask the family, and if the resident is alert and oriented, ask them what their abilities are.
On 1/17/15 at 4:44 PM E6 & E10 Certified nursing assistants (CNA) said "we transfered R1 two times." E6 said R1 was a little shaky, so we transfered R1 together (two person assist). On 1/23/15 at 3:05 PM, E10 said that on 01/09/15 at 8:55 PM, after placing R1 on the bed side commode (BSC), E4 Licensed Practical Nurse (LPN), asked E6 and I (E10) when we (E6, E10) get her (R1) up that she (E4) would like to check her bottom for any skin issues. E6 and E10 went on to other rooms while R1 used the BSC. E6 and E10 both stated that they returned to R1 ' s room when they heard E4 yelling for help.

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On 1/17/15 at 4:06 PM, E4 said, information about R1 ' s ability to transfer came from the hospital, family, and resident. E4 said, on 1/09/15 at 9:00 PM, when R1 was finished urinating E4 asked R1 to get into the bed so E4 could do a skin assessment. R1 said she would rather stand, and that she (R1) could lean against the back of the recliner for support. E4, without the aid of the 2 CNA ' s, said she cleaned R1 ' s perineal area and R1 leaned against the back of the recliner while E4 attempted to assess R1 ' s labia and bottom. R1 then said, " I have to sit, I have to sit! " E4 said R1 started to lean forward. R1 ' s legs spread to the point where she could not sit back down on the bed side commode. E4 said she eased R1 to her knees and ran to the doorway and yelled for help. At this point R1 ' s knees started to spread further appearing to do the " splits " with both her legs to each side and behind her. On 1/23/15 at 2:00 PM, E4 stated that R1 was standing less than 1 minute, maybe 45 seconds. E4 said when help came, we used a mechanical lift to put her on the bed. E4 said that R1 rated her pain at a 10 (0= No Pain and 10= worst pain ever).

On 1/23/15 at 3:00 PM, Z3 said she did tell the facility that R1 can stand, pivot, sit, but that takes only 10 seconds and R1 was standing for longer than that. She spent the last 7 days in the hospital and she is weak. Z3 said, " R1 has arthritis and a bad back, and hasn ' t walked in years. I told the facility all that. Why didn ' t that nurse have help if she was going to do an assessment? "

On 1/17/15 at 4:00, PM E5 Registered nurse (RN) said, to assess the abilities of a resident when rehab is not here to do it, the staff looks at what the hospital documented, the nurse and the CNA should do a quick assessment, and ask the resident what their abilities are if they are alert and oriented. I expect the staff to use a gait belt

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and proper body mechanics.
On 1/23/15 at 12:15 PM, E2 Director of Nursing (DON) said, she expects that if a resident is admitted after rehab is gone, the nursing staff will look at the hospital assessment and discharge summary to assess the abilities of that resident to transfer, stand, and walk. E2 also said the resident is a good source of information if they are alert and oriented. In this case E2 stated, " I think she (R1) had a bad hospital stay and thought she (R1) could do something, but her (R1) body was tired and she couldn ' t do it. "
On 1/27/15 at 10:35 AM, Z1 Medical Director/Medical Doctor, said that the nursing staff would be responsible for accurately assessing a resident that arrives after rehab leaves for the day. Z1 said to err on the side of caution, and use more help than you think you need until you know what the abilities of that resident is, especially one of that size, age and medical history.
On 1/12/15 at 3:45 PM, E4 made a late nursing note entry for 1/09/15 at 9:00 PM. " Patient was sitting on commode in her room. Reported to this nurse (E4) that she (R1) could stand for assessment of her skin on her bottom ...She (R1) said I can hang on to the recliner ...She (R1) stood in front of the commode after some trouble removing from its sides ...She (R1) began to say I have to sit, I have to sit. Her (R1) feet had slid slightly apart and were now on the outside of the commode chair legs so the commode would not slide up behind her. She (R1) began leaning her head into the recliner seat and was lowered onto her knees by this nurse(E4) ...She (R1) was very frantic at this time calling for 911 ...This nurse (E4) stepped into the doorway and called for " help now. " Several CNA ' s and the PM supervisor (E5) came to assist. While assessing R1 ' s position and getting the mechanical lift

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device, the patient slid her knees apart appearing to do the splits with both legs now out to the sides of her (R1) and was no longer on her knees. She was mechanically lifted on to the bed. Complaining of pain all over after in bed. "
The hospital physical therapy notes for R1 dated 1/8/15 at 3:11 PM list R1 ' s prior ambulation as " Non-ambulatory " . Under the heading, Social/Home Environment Comments, shows, " Hasn ' t ambulated in 4-5 years. Under the category of Activity Tolerance Comments, it states R1 has poor activity tolerance, and is " very shaky " . The 3 categories of, Sit to Stand, Stand to Sit, and Chair Transfer Ability list R1 as a " Contact Guard " (Have hands on the body in case there is a need for assistance). This document listed R1 ' s limiting factors as " Decreased Balance, and Decreased Strength.
On 1/22/15 at 3:30 PM, E2 DON states, we received this document after the incident occurred.
The 1/11/15 local hospital ' s Discharge Summary shows R1 injuries as bilateral hip fracture.
The facility ' s Fall Prevention Program policy dated 6/18/13 under the heading, Policy Statement states, " The corporate ministry guiding principle is that all patients/residents are at risk for falls. All Presence life Connections Nursing Home employees have a role in fall prevention.

(B)