Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6011746	A. BUILDING: ______ B. WING ______	C 12/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MANOR NRSG & REHAB CTR	**345 DIXIE HIGHWAY** **CHICAGO HEIGHTS, IL 60411**

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S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1010h) 300.1210d)3) 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 of care for the care or treatment of such accident, injury or change in condition at the time of	S9999		

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notification.

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:
3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

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.

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These Regulations were not met as evidenced by:

Based on observation, interview and record review, the facility failed to follow their policy and perform safe mechanical lift or two person transfers for 3 of 4 residents (R1,R2,R3) reviewed for falls.
This failure resulted in R1 slipping during the transfer and sustaining a fractured left arm.

Findings include:

On 10/28/14 at 3pm, E3(Nurse) stated R2 will be transfered back to bed by mechanical lift, but the transfer is done with 2 people. At 3:05pm, R2 sat in the wheelchair at the side of the bed.
E4(Nurse Aide) and E5(Nurse Aide) placed the sling for the lift on the left side of R2 and pulled it back behind and under R2. To position the sling, E4 and E5 had to lift R2's upper body forward, then lift R2's legs and pelvis up off the wheelchair seat. E4 and E5 attached the sling to the lift and as E4 operated the machine, E5 guided R2 in the sling. Once R2 was up in the air and without the support of the wheelchair, R2 tilted to the left side and the sling was not under the right side of his body. As E4 and E5 continued the lift and were moving R2 away from the wheelchair, they were prompted by the surveyor to stop the transfer. R4 and R5 stopped the transfer and verified that the sling was not placed properly around R2. R4 and R5 continued to adjust and reposition the sling under R2 for 6 more minutes before reattaching the sling to the lift and proceeding with the transfer.

Facility Incident Report Form 8/1/14 11pm
Description of Occurrence R1 verbalized left

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shoulder pain, physician notified and received an order for an x-ray. X-ray report 8/2/14 documents a fracture of the left humerus.
Statement of Events 8/5/14 E6(Nurse) cared for R1 on 8/1/14 6am-2pm shift. R6 was told by E8(Social Service) that R1 had left shoulder pain, rating 5 out of 10 on the pain scale, and E8 reported to E6 and the oncoming nurse (2pm-10pm shift) that R1 reported almost falling in the bathroom while being transfered with the standing lift. Statement of Events 8/5/14 E7(Nurse Aide) cared for R1 on 8/1/14 6am-2pm shift. E7 transfered R1 alone using the standing lift. R1 complained of pain to the left arm during the transfer, R1 did not fall. Typed interview 8/5/14 with E8 documents that on 8/1/14, R1 told E8 that her left shoulder hurt and that R1 almost fell during a transfer. E8 reported it to the nurse in charge. Progress Note 8/6/14 documents E1(Administrator) spoke with Z2 about the evnet on 8/1/14. E1 told Z2 that R1 almost fell during the transfer, and E8 reported this to the nurses.

On 10/29/14 at 11:25am, E6 stated E8 came to the nurse's station on 8/1/14 and said that R1 told her that she almost fell in the bathroom when being transferred and complained of pain in the left shoulder. E6 stated she was leaving for the day, and expected E8 to follow up with the doctor. If a resident said that they almost fell and now had pain, E6 would have called the doctor.
On 10/29/14 at 11:45am, E8 stated that on 8/1/14, R1 told her that she nearly fell during a transfer and now had pain in the left shoulder. E8 told 2 nurses at the change of shift.
On 10/29/14 at 12:20pm, E7(Nurse Aide) stated that on 8/1/14 approximately 11am, during a standing lift transfer, R1 told her she felt like she was slipping. E7 stated she did not tell the nurse. E7 stated she performed R1's transfer by herself

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when it should have been done with 2 people. On 10/29/14 at 1:30pm, Z1(Physician) stated that R1 fractured the left arm during the transfer and Z1 did not receive a call from the nurse until later that night on 8/1/14. Z1 stated an x-ray would have been ordered sooner if he knew about the change in pain in R1's left arm and the near fall during the transfer.

During the fall on 8/18/14, R3 was transfered by one staff member. R3 was changed to a 2 person transfer with a gait belt after the fall on 8/18/14 because R3 refused the mechanical lift for transfers. Event on 8/21/14, R3 was transfered by one person.
Restorative Nursing Assessment 7/30/14, R3's transfer status is a two person transfer.
Care Card (undated) documents R3 as a two person transfer with a gait belt.
On 11/19/14 at 1:20pm, E12(Restorative Nurse) stated R3 refused the mechanical left for transfers, so she was assessed as a 2 person transfer with a gait belt as on the care card.
Fall Care Plan is not updated after the fall on 8/18/14.

Using a Protable Lifting Machine policy - The protable lift should be used by two staff member. Place the sling along the back of the resident. Be sure the top of the sling is at the head of the resident and the bottom at the resident's knees.
Investigating and Reporting Accidents/Incidents/Events policy - Regardless of how minor an accident or incident may be, including injuries of an unknown source, it must be reported to the department supervisor as soon as such accident/incident is discovered or when information of such accident/incident is learned. The Nurse Supervisor/Charge Nurse must be immediately informed of accidents or incidents so

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