STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145502	A. BUILDING _____ B. WING _____	C 09/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAYLORVILLE CARE CENTER	600 SOUTH HOUSTON TAYLORVILLE, IL 62568

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F 000	INITIAL COMMENTS	F 000		
F 157 SS=D	Complaint #1644993/IL88162 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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by:
Based on record review and interview, the facility failed to immediately inform a Power of Attorney (POA) over healthcare of a fall which resulted in injury for one of 3 residents (R3) reviewed for falls with injury in the sample of 9.

Findings include:

1. An Incident Report, dated 8/22/16, documents at 6:33 AM, R3 fell to the floor during a full body mechanical lift transfer when the straps of the sling broke sustaining a severe head injury. R3 was transported immediately to the local hospital for evaluation and treatment. The Incident Report documents that Z1, R3's POA over Healthcare, was notified at 8:50 AM, 2 hours and 20 minutes after R3's incident.

On 8/31/16 at 9:35 AM, Z1 stated he was not aware of the fall and subsequent injury until the local hospital called him for permission to treat. Z1 stated he called the facility following the call from the hospital and was told by E9, Registered Nurse (RN), that R3 had fallen and was transferred out with severe injuries.

On 8/31/16 at 9:55 AM, E9 confirmed that she did not contact R3's POA, Z1, immediately after the incident, but told him when he called the facility after he had been informed by the local hospital. E9 stated she was "hopeful management had notified him" since she had notified E14, nurse on call. E9 acknowledged that it was a mistake not to call them herself.

The facility policy entitled "Transfer Procedures Emergency - to Hospital," dated 10/2010, documents that in the event of an injury or acute

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F 157	Continued From page 2 illness of a resident, the nurse will notify the family or responsible party of the transfer to the hospital.	F 157		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and record review, the facility failed to follow manufacturer's recommendations for use of a full body mechanical lift for 2 of 3 residents (R2, R3) reviewed for mechanical lift transfers in the sample of 9. This failure resulted in R3 falling during a transfer and sustaining a bilateral subarachnoid hemorrhage. Findings include: 1. The Minimum Data Set (MDS), dated 7/22/16, documents R3 has severe cognitive impairment and is totally dependent on staff for all activities of daily living including transfer. The Care Plan, dated 7/25/16, documents R3 is a mechanical lift with assist of 2 and uses a wheelchair for locomotion throughout the facility requiring total assist of staff.	F 323		

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An Incident Report, dated 8/22/16, documents R3 fell to the floor in her room at 6:33 AM during a full body mechanical lift transfer from her bed to the wheelchair by 2 Certified Nurses Aides (CNAs), E4 and E5. The Report documents "while in the sling, the (mechanical) sling strap broke causing the resident to fall to floor. Note laceration c (with) bleeding to the back of the head. EMS (emergency services) called et (and) transferred to ER (Emergency room.)" The Report documents R3 being transferred to a larger hospital for evaluation and treatment. The Report documents the investigation determined the sling had no fraying, thread breakage, rips or tear that would account for the sling tearing.

The Manufacturer's Handbook, dated 2013, documents recommendations for this particular lift that directs staff to position wheelchair and lock wheels before transferring the resident from the bed to the wheelchair. The recommendations also document staff are to ensure the straps are attached correctly after lifting from the bed and before moving the resident toward the wheelchair. The Incident Report does not reflect whether staff did this or not prior to transferring R3.

On 8/30/16 at 1:00 PM, E4 and E5 were interviewed. E4 stated they (E4 and E5) had hooked R3 up and lifted her off the bed. E4 stated she reached over and pulled R3 over from above the bed as she reached back for the wheelchair when she her a "pop pop" and R3 fell to the floor. E4 stated she did not have the wheelchair locked as they usually "pull it underneath" the resident as they move the lift over. Both E4 and E5 stated the wheelchair was not positioned or locked prior to lifting R3 from

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the bed with the mechanical lift. Neither stated they checked the straps once they lifted R3 off the bed and before they moved her toward the chair. E4 stated the strap broke at R3's hips first, then the one by her shoulder causing her to fall and hit her head on the floor. E4 demonstrated at bed side that she was to the side of R3 trying to pull the wheelchair into place when R3 fell. E5 stated she was running the controls of the machine and had pulled the legs of the lift out from under the bed and moved her from over the bed when the straps broke. Neither CNA was in a position to break R3's fall from where they stood and E4 did not have control of R3. E5 stated she has been inserviced on using the full body mechanical lift since the incident occurred with R3.

On 8/31/16 at 9:55 AM, E9, Registered Nurse (RN), stated she was called to the room after R3 fell. E9 stated that when she entered the room, R3 was on the floor with the sling under her, upper body towards the end of the bed and legs over the leg of the lift. E9 stated she saw blood coming from R3's head and immediately called to have her transported to the emergency room.

R3's hospital Discharge Records, dated 8/25/16, document R3 had a bilateral subarachnoid hemorrhage resulting from a fall at the nursing home.

R3's Progress notes, dated 8/25/16, document R3 returned to the facility at 1850 (6:50 PM) with end of life care (Hospice) due to bilateral subarachnoid hemorrhage. R3's Progress notes, dated 8/30/16, document R3 expired.

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2. On 8/30/16 at 10:56 AM, E5 and E6, CNA, entered R2's room to transfer her to the wheelchair using a mechanical lift. The sling for the mechanical lift had already been placed under R2. E6 and E5 hooked R2's sling to the lift as she lay flat in the middle of the bed and E6 took the controls of the lift. R2 was lifted several inches above the bed then E6 moved her back as E5 turned her around and pulled her over toward the wheelchair which was located at the foot of the bed. The wheelchair wheels were not locked and as E5 took control of R2 by grabbing the sling straps on the back of the sling and moving her over the wheelchair, the wheelchair tipped backwards into E5. E5 moved R2 above the seat of the wheelchair and E6 lowered the sling/R2 into the seat of the wheelchair. Neither E5 or E6 checked the straps once R2 was lifted from the bed nor was the wheelchair positioned and the wheels locked prior to the lift as recommended in the Manufacturer's handbook.

On 8/30/16 at 9:45 AM, E1, Administrator, and E2, Director of Nurses (DON), stated inservicing on mechanical lifts had been done since the incident occurred with R3 even though her fall was caused by the straps breaking. E2 stated E10, Therapy Director, had trained E11, Licensed Practical Nurse (LPN)/Restorative Nurse, and she had started training and doing repeat demonstrations for all CNAs.

On 8/30/16 at 4:20 PM, E11 stated she had been doing some inservicing on the mechanical lift and had approximately 15 more CNAs to do. E11 stated she was unsure about whether to lock the wheelchair or not prior to transferring, but stated she knew the lift itself was not to be locked.

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F 323	Continued From page 6 On 8/30/16 at PM, Z3, Supplier of the lift, stated proper positioning for using the particular lift would be to have everything including the wheelchair in position prior to lifting the resident. On 8/31/16 at 9:45 AM, E10 stated she did inservicing to E11 and some direct care staff, but they have more to do. When asked about positioning and locking the wheelchair prior to lifting residents, E10 stated she tells staff to not lock the lift itself, but you can or don't have to lock the wheelchair. E10 stated it is very important for one person to have control of the resident in the sling at all times referring to have hold of the straps at the back of the sling when the resident is moved from over the bed to the wheelchair. E10 stated she has not looked at the handbook, but had training in this by the manufacturer approximately one year ago. E10 stated they did not focus on wheelchair positioning in a bed to wheelchair transfer, but not locking the lift so the point of gravity is maintained to prevent the lift from tipping. E10 stated again, that a staff member should have control of the resident in the sling at all times.	F 323		