STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145601	A. BUILDING _____ B. WING _____	C 01/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVISTON COUNTRYSIDE MANOR	450 WEST 1ST STREET AVISTON, IL 62216

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F 000	INITIAL COMMENTS Incident Report Investigation to Incident of 12/12/2016/IL90900	F 000		
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide a safe transfer to prevent a fall for 2 of 8 residents (R1 and R3) reviewed for falls in the sample of 8. This failure resulted in R1 sustaining a fracture of the	F 323		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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left femur and hospitalization.

Findings include:

1. The ECR (electronic clinical record) for R1 documents diagnoses, in part, as Osteoarthritis, Pain in Left and Right Hip, Difficulty Walking, Unsteady on Feet, Angina Pectoris, Atrial fibrillation, Chronic Obstructive Pulmonary Disease, Dementia, and Chronic Kidney Disease.

R1's Minimum Data Set (MDS), dated 9/20/2016, documents R1 is moderately impaired with cognition, transfers and ambulates with an extensive assistance of 2 staff and has impaired range of motion in the lower extremities. The MDS documents R1 has unsteady sitting and standing balance.

R1's Morse Fall Scale, dated 9/11/2016, documents R1 is a high risk for falls.

The Fall Investigation, dated 12/12/2106 at 10:00 PM documents, in part, "CNA (Certified Nurse's Aide) was assisting (R1) to bed from the commode that was right next to the bed, when the bed began to move backwards. CNA (E4) began to lower (R1) to the floor when she heard a POP from the resident's body. Upon entering the room, nurse noted (R1) to be laying on the floor with back leaning against the bed, with the LLE (left lower extremity) externally rotated. (R1) complained of pain to the area. (R1) was not moved at this time. (Z1), Physician notified and orders given to send (R1) to the (local hospital) ER (emergency room) for evaluation and treatment. 'I was going to bed, and I just started going down.' Predisposing Environmental Factors-Furniture. Predisposing Situation

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Factors-Improper Footwear. Bed wheel locks were not completely locked, causing the bed to move, resulting in (R1) being lowered to the floor. (R1) was ultimately admitted with a left femur fracture. Investigation revealed the CNA, (E4) involved in the transfer was not using a gait belt. Also per Care Plan, (R1) is to be transferred with 2 assist due to fluctuations in strength and history of knees giving out when standing. (R1) was being transferred with assist of 1 at time of incident. Disciplinary action was taken by DON, (Director of Nursing) towards CNA involved. She was suspended X 3 days. Also DON (E2) conducted inservices with all CNA's on gait belt policy."

On 1/05/2017 at 3:07 PM, E4 reported on 12/12/2016 around 9:55 PM, she and E5, CNA, had put R1 on the bedside commode. E4 stated, in part, " (E5) left to put someone else to bed. I stood (R1) up from the commode. I was facing (R1). I hugged her and picked her up to turn her back toward the bed. When she (R1) went to sit down, the bed scooted back. I went to put her back on the commode, and before I could turn her, I heard a POP. Her body started giving out. She's short and wide. I lowered her to the floor. There was no help coming from her anymore. When I sat her down on her bottom, her legs were straight out in front of her. I asked her if she was OK, and she said she was fine. I left, walked out the door and called (E5). (E5) came out and got the nurse, (E6), Licensed Practical Nurse (LPN). When I went back in, I noticed her leg was crooked. (E5) and (E6) came in." E4 reported she did not place a gait belt on R1 prior to the transfer.

On 1/05/2017 at 3:25 PM, E5 reported that on

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12/12/2016 she and E4 had placed R1 on the commode without using a gaitbelt. E5 reported she left to answer a call light and when she was done, E4 told her to get the nurse because R1 was on the floor. E5 reported she went and got E6, and both entered R1's room. E5 reported R1 was alert and awake, with the left leg turned inward. E5 stated R1 reported she was alright and E6 left to notify E7, LPN, an ambulance and a doctor. E5 reported R1 usually can be a one assist, but her Care Plan says 2 assist. E5 confirmed a gait belt should have been used for R1 for the transfer.

On 1/05/2017 at 3:58 PM, E6 reported on 12/12/2016, E4 came and got her and reported R1 had fallen. E6 stated, in part, "I knew she (R1) had previous knee problems, and was a 2 assist with a gait belt. (R1) was alert and awake, lucid. Then I scanned down and noticed a major left external rotation and complaints of left leg pain. I said I wasn't moving her, and I called (Z1). I called 911 and the ambulance arrived. Her vital signs were normal. When the EMT's (emergency medical technicians) took her vital signs, her blood pressure was lower." E6 reported R1 left by ambulance and never returned to the facility.

On 1/05/2017, at 12:40 PM E1, Administrator, reported R1 was sent to the local hospital on 12/12/2016 and was discharged from the facility. E1 reported R1 received hospice services at the local hospital for the diagnosis of Advanced Dementia.

On 1/05/2017 at 3:50 PM, E2, Director of Nursing (DON) stated, "All residents need use of a gait belt unless they are transferred with a mechanical lift. (E4) was suspended for 3 days."

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R1's Care Plan, updated 11/01/2016, documents, in part, "I have an ADL (activities of daily living) self-care performance deficit related to limited mobility and pain related to Osteoarthritis. TOILET USE: I need assist of 2 caregivers. TRANSFER: I need assist of 2 caregivers. 9/23/2016 Skilled PT (physical therapy) to evaluate and treat related to recent falls and pain to my right leg and lower back. Provide me with a wheeled walker. Place a gait belt around my waist."

The History and Physical (H&P) from Z1 at the local hospital, dated 12/12/2016, documents R1 was alert, and verbalized the accident. The H&P documents R1 was stable, and her family requested she be referred to an orthopedic surgeon at an out of state hospital. The Hospital record documents R1's family refused the surgery due to the risks. R1 was certified and placed on hospice on 12/16/2016 per the family's request for the diagnoses of Senile Degeneration of the Brain, with the coexisting diagnoses of Atrial fibrillation and Unspecified fracture of the left femur, subsequent encounter for closed fracture with routine healing.

The facility's policy and procedure, dated 4/01/2008, and entitled, 'Low Risk for Falls Protocol' documents in part, "Procedure: Wheel locks on bed are locked. Resident will be offered the use of a transfer assist device for the bed as appropriate."

The facility's policy and procedure, dated 3/1996, and entitled, 'Gait Belt/Transfer Belt' documents, in part, "A gait belt/transfer belt will be utilized by

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facility staff when deemed appropriate by Physical Therapy and/or Nursing. Purpose; To promote safety in transferring and ambulating residents. CNA's will routinely wear gait/transfer belts on their person until needed during resident care. The Licensed Nurse/CNA, when transferring or ambulating the resident, grasps the secured gait/transfer belt to provide stability and balance during movement. Once resident has been moved and safely repositioned, the gait/transfer belt is removed from the resident and the CNA keeps it on his/her person until next resident use."

2. R3's ECR documents diagnoses, in part, as Hemiplegia, Hemiparesis, Osteoarthritis, Convulsions, and Dementia.

R3's MDS, dated 9/02/2016, documents R3 is severely impaired with cognition and requires the extensive assistance of 2 staff for transfers, with poor sitting and standing balance. R3's Care Plan, revised on 8/03/2016, documents R3 is a high risk for falls. R3's Care Plan documents, in part, "I am at high risk for falls. I use a wheelchair for my main mode of mobility. I need 2 assist with transfers."

On 1/05/2017 at 1:00 PM and 2:55 PM, R3 was propelling herself in a wheelchair using her feet. R3 was very confused, but talkative and alert. There were anti-tippers on the back of the wheelchair. R3 was sitting on a slick vinyl, gel pressure relieving cushion in the wheelchair.

The Fall Investigation for R3, dated 11/06/2016 at 2:13 PM, documents, in part, "Resident (R3) was taken to bathroom and cleaned up due to having BM (bowel movement). (R3) transferred to

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F 323	Continued From page 6 wheelchair and due to buttocks still being wet from cleaning, she slid off wheelchair and fell to the floor. Resident buttock wet and bare when placed in wheelchair. Injury type-abrasion to right trochanter (hip). Nurse on duty educated CNA, (E12) on ensuring seat and buttock is dry prior to transferring resident into location." The Investigation documented one CNA transferred R3 at the time of the incident.	F 323		