STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145846	A. BUILDING _____ B. WING _____	C 01/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD CARE CENTER OF EDWARDSVILLE	**6277 CENTER GROVE ROAD EDWARDSVILLE, IL 62025**

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F 000	INITIAL COMMENTS Complaint #1647374/IL90763	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 interview, observation and record review, the facility failed to follow facility policy/procedure for safe transfer of residents using a full mechanical lift with the assistance of two staff and failed to provide adequate supervision/safety devices during shower time for	F 323		

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

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F 323	Continued From page 1 2 of 3 residents (R3, R1) reviewed for falls in the sample of three. This failure resulted in R3 falling out of the full body mechanical lift sling during a transfer sustaining a bilateral subdural hematoma which resulted in death. Findings include: 1. The Minimum Data Set (MDS), dated 8/11/16, documents R3 to have severe cognitive impairment and be dependent on two staff for transfers. The MDS also identifies her to be aphasic. A Fall Risk assessment, dated 9/29/16, documents R3 to be at significant risk of falls. The Care Plan, dated 8/17/16, documents R3 has a diagnoses of Cerebral Vascular Accident with right hemiparesis and to have a self care deficit requiring total assist of all activities of daily living (ADL) and requiring a full body mechanical lift for transfers. There is no fall prevention plan in the Care Plan. The October 2016 Physician's Order Sheet (POS) includes an order for a full body mechanical lift to be used in transfers. The POS also documents R3 receives Coumadin (a blood thinner) daily. An Incident/Accident Report completed by E4, Licensed Practical Nurse (LPN), dated 10/20/16 at 8:30 PM, documents "CNA (Certified Nurse Aide) reported to nurse that resident fell. CNA put resident back in bed before reporting fall to nurse." The report identifies the CNA as E3. The report documents R3's injuries as a 6 centimeter (cm) circular hematoma to the head. The	F 323		

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physician was notified and orders were received to send to the emergency room for evaluation.

Nurses Notes, dated 10/20/16 written by E4, documents R3 was transported at 9 PM and on 10/21/16, R3 returned to the facility at 12 AM with orders for an ice pack and neurochecks every 6 hours.

Nurses Notes document R3 was seen on 10/26/16 at 11:30 AM by Z1, Medical Director, following the fall with new orders noted, but no change in condition documented by either Z1 or the nurses.

On 11/1/16 at 3:30 PM, the Nurses Notes document the CNAs notified the nurse that R3 was "off" and wasn't responding to touch as usual. Z1 was notified and orders were received to send to the hospital. The Nurses Notes, dated 11/1/16 at 9:30 PM, document a hospital representative stated resident had brain bleed in multiple spots and family had admitted resident into Hospice.

A Death Certificate documents R3 expired on 11/2/16 with cause of death documented as "Bilateral Subdural Hematoma" due to "fall."

On 1/4/17 at 10:45 AM, E1, Administrator, identified E3 as the CNA involved in R3's fall. E1 stated it was explained to her that E3 chose to transfer R3 by herself with no assistance and when E3 started to raise R3 up from the wheelchair with the lift, the top strap of the sling came undone causing R3 to lean sideways and fall to the floor. E1 stated E3 said she lowered her to the floor then used the lift to transfer her to bed before notifying the nurse of the fall which

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she shouldn't have done either. E1 stated she should have left R3 on the floor and notified the nurse. E1 stated the facility has had no other incidents with falls from the mechanical lifts and E3 had been inserviced on proper use of the lifts, including requiring two staff members, prior to the fall incident occurring with R3. E1 stated staffing was fine on the hallway that night adding that there were two other CNAs on 100 hall at the time. E1 also stated E3 has been disciplined for not following facility policy. At 11:18 AM, E1 stated E3 offered no explanation as to why she didn't have another staff member help her and that staffing that evening was adequate.

On 1/4/17 at 2:36 PM, Z1, Medical Director, stated it was his understanding that E3 did not follow facility protocol to use two staff members in transferring and that the sling was not properly attached to the lift. Z1 stated he thought R3 sustained a slow bleed during the fall which resulted in the subdural hematoma. Z1 acknowledged he saw R3 several days after the fall and did not notice any change in consciousness at that time nor was he informed of any change until 11/1/16 when she became unresponsive.

E3's employee file includes a disciplinary action for following policy/procedure when using full body mechanical lifts. The file also contained a safety policy for using mechanical lifts signed by E3, dated 4/10/14. The Procedure documents, in part, "Total mechanical lifts require a minimum of 2 trained staff members to complete a resident transfer."

The Facility policy entitled "total resident transfers using Mechanical lifts," dated 3/31/08, documents

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staff members will ensure residents safety during total transfers of residents. Under procedure, it documents only trained employees will use the lift and total mechanical lifts require a minimum of 2 trained staff members to complete the transfer. The procedure also directs employees to follow the manufacturer's directions when using the lifts.

The Manufacturers directions document the lift has the option of both a 6 point sling or a 4 point positioning cradle sling with both systems using a different attachment method and sling. The guide assumes the straps will be properly attached to the lift arm and secured prior to lifting the resident.

2. The MDS, dated 9/2/16, documents R1 to have severe cognitive impairment and short/long term memory deficits. The MDS documents R1 requires extensive assist of two staff for mobility and is unable to move from one point to another without the assistance of staff.

The Care Plan, dated 9/15/16, documents R1 has had several falls from bed and two falls during shower/bath time with interventions for fall preventions to include a lap top cushion to prevent unsafe transfers - unable to remove during mealtime due to anxiety, non-slick footwear that fits, and raised edged low bed with mattress on the floor in part.

An Incident/Accident Report, dated 8/18/16, documents at 9:45 PM that "resident slid out of w/c (wheelchair). She was wet coming from a shower." Injuries identified as skin tear to left buttocks. E6, CNA, witness statement documents R1 "was in her chair and slid out of her chair, (mechanical lift) pad was wet under her and her

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feet were wet." The investigation does not include an analysis of the fall for causative factors and no interventions were added to the fall prevention plan to ensure safe transfer during and to/from showers.

An Incident/Accident Report, dated 10/1/16 at 4:30 PM, documents another fall during shower time for R1. The Witness Statement with the report written by E7, LPN, documents "CNA was giving resident shower. I saw CNA looking for help at the shower room door. Before I enter the room I heard something fall, walked in and saw resident laying on the floor." E7 documented R1 had "one slipper sock" on and had been in the shower chair prior to the fall. The CNA identified as being at the door of the shower looking for assistance was E5, CNA. Her witness statement documents "resident tried to get out of shower chair and fell." Again, there is no causative factor identified in the report. However, there is an "Inservice Education/Meeting Attendance" sheet, dated 10/3/16, attached to the investigation which documents "All residents whom are (full body mechanical lifts) MUST be showered on the shower bed." The facility failed to identify E5 turning her back on R1 as she sat in the shower chair without her lap top cushion as a causative factor as well. E5 was not one of the participants of the in-service education regarding the shower bed use for all full body mechanical lifts residents.

R1's Care Plan, as of 1/6/17, does not include any interventions toward safe transfers during shower time.

On 1/4/17 at 2:30 PM, when was asked about R1's falls prevention plan not including any interventions or directions to staff regarding

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F 323	Continued From page 6 safety during shower time and transfers, E9, Care Plan Coordinator/LPN, stated she's not sure how those falls occurred, she just lists the falls on the Care Plan. On 1/4/17 at 2:36 PM, Z1 stated R1 has repeated falls and the facility is responsible to ensure adequate supervision is provided and shouldn't be left alone in the shower. Z1 was unsure how the fall during the transport down the hall occurred and could not comment. On 1/6/17 at 11:30 AM, E1, Administrator, stated it is a facility policy for all residents transferred via a full body mechanical lift to have a shower bed used for shower and transport. E1 stated R1 should have been in a shower bed both times her falls occurred. E1 stated she didn't think there was a written policy on it, but that it is known by all staff that a shower bed is to be used by residents requiring the full body lift. When asked why using the shower chair wasn't an intervention within R1's falls prevention plan, E1 stated all staff were aware, even though both R1's falls involved 2 separate CNAs. E1 was unaware as to why the CNAs did not use a shower bed or if they were unaware they needed to. On 1/6/17 at 12:30 PM, E2, Director of Nurses, also stated she was unaware of whether the CNAs involved in R1's falls were not aware of the facility policy to use a shower bed or if they chose not to at the time. E2 stated both CNAs are no longer employed at the facility.	F 323		