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
	IL6008973	A. BUILDING: _____ B. WING _____	C 08/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Facility Reported Incident of 8/18/2019/IL115041 investigation	S 000		
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	S9999	**Attachment A** **Statement of Licensure Violations**	

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 08/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 1	S9999		

resident to meet the total nursing and personal care needs of the resident. Restorative measures 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.

These regulations were not met as evidence by:

Based on observation, interview, and record review the facility failed to safely transfer a resident using a mechanical lift for one of three residents (R1) reviewed for falls in the sample of 5. This failure resulted in R1 sustaining a head laceration that required two staples and being admitted to the hospital for pain control for hip and back.

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 08/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 2 The findings include: The facility assessment dated 8/5/2019 shows R1 to have severe cognitive impairment, no behaviors, requires extensive assist with all care including bed mobility and transfers. The assessment also shows R1 has impaired range of motion to both upper and lower extremities and weighs 270 pounds. On 8/27/2019 at 8:45 AM, R1 was observed being transferred using the mechanical lift by 2 CNA's (Certified Nursing Assistant). R1 remained completely still during the transfer and was unable to move R1's legs while in the sling when this surveyor asked R1 to move R1's legs. R1 had a large old bruise behind her left knee and brusing to R1's right arm. The facility incident report dated 8/18/2019 shows R1 was being transferred by mechanical lift with two CNA's. The report shows R1 slipped out of the mechanical lift and was lying on the floor on R1's back in a pool of blood surrounding R1's head. The report also shows as the 2 CNA's were lifting R1 out of R1's wheelchair, one CNA moved the wheelchair from under R1 and then was moving back next to the resident when the attachment to the lift came undone to R1's right leg and R1 slid to the floor. The report shows R1's head was the first to hit the floor before the rest of her body slid to the ground. On 8/27/2019 at 9:35AM, V6 CNA said she was the staff assisting R1 to bed when (R1) fell from the mechanical lift. V6 said she attached R1's sling to the lift on the right side while the other CNA did the left. V6 said the other CNA began to lift R1 up and V6 pulled the wheelchair out from under R1 as R1's bottom came up off the	S9999		

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 08/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 3	S9999		

wheelchair. V6 said R1 was not moving while being lifted and remained still. V6 had moved the wheelchair away from R1 and when she turned to go back to R1, R1 's right leg attachment to the lift came off and R1 slid to the floor. V6 said R1's head hit the floor first and the rest of R1's body just followed along. V6 said R1 was bleeding from R1's head and crying out in pain.

On 8/27/2019 at 10:00AM, V7 CNA said she was assisting R1 from R1's wheelchair using the mechanical lift when R1 fell to the floor. V7 said she hooked up the left side of the sling and was in charge of raising the mechanical lift. V7 said as R1 was being lifted R1 remained still in the sling, the other CNA moved the wheelchair from under R1 and the right side leg attachment came off and R1 slid to the floor hitting R1's head first. V7 said R1 was bleeding from R1's head and crying out in pain.

On 8/27/2019 at 12:15 PM, V4 LPN (Licensed Practical Nurse) said she was in another room that day when she heard a loud commotion in the hall followed by a resident screaming. V4 said V7 came to get her saying R1 had fallen out of the mechanical lift. V4 said when she entered the room she saw R1 on R1's back on the floor with a pool of blood under R1's head. V4 said R1 was awake and crying because of the pain. V4 said R1 was sent to the hospital by ambulance.

On 8/27/2019 at 9:40 AM, V1 Administrator, V2 DON (Director of Nursing), and V3 Restorative Nurse said the conclusion of their investigation into the fall was that R1 must have lifted R1's leg up and the attachment came undone on the right leg. R1 was lying on the floor and the only attachment undone on the mechanical lift was the

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 08/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 4	S9999		

right leg. During the investigation it was determined that R1 hit R1's head first and the rest of the body just slid out to the floor.

On 8/27/2019 V5 LPN, V8 and V9 CNA's said they do not believe that R1 could lift R1's legs while in the mechanical lift sling. R1 can barely lift R1's legs while lying in bed. V8 said one time she did not have the sling attached all the way to the lift and as she raised the lift she noticed the resident coming out of the sling. V8 said she has never seen the clips come off the lift unless they are not attached properly.

On 8/27/2019 at 2:55PM, V2 DON said she expects her staff to transfer the residents in the safest way possible to avoid any injury.

The facility nursing notes shows R1 was experiencing pain to R1's head and body after returning from the hospital. Bruising was identified to R1's right wrist, right elbow and and open skin to back of the left knee.

The hospital records dated 8/18/2019 shows R1 was dropped from the mechanical lift approximately four feet. The head laceration required two staples and initial x-ray showed possible fracture to her right hip. The follow-up cat scan did not show a fracture. R1 was admitted to the hospital for pain control to her right hip and upper back after the fall.

The operating and product care instructions for the mechanical lift shows: caution: always check that all the sling attachment clips are fully in position before and during the lifting cycle, and in tension as the patients weight is gradually taken up.

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 08/27/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 5 The facility policy for mechanical lifts with a revision date of 11/2018 shows the use of the mechanical equipment should be according to manufactures recommendations. (B)	S9999		