STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009989	A. BUILDING: _____ B. WING _____	C 05/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREGON LIVING AND REHABILITATION CENT	811 SOUTH 10TH STREET OREGON, IL 61061

(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 5/2/19/ IL 112044 investigation	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b)4)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**	

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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:

4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.

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

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S9999	Continued From page 2	S9999		

resident

These regulations are not met as evidence by:

Based on Observation, Interview and Record Review the facility failed to provide safety and supervision of a resident during a transfer with a mechanical lift. This failure resulted in R1 falling out of a sling during a mechanical lift transfer on 5/2/19 and sustaining a distal fracture of her right femur, closed head injury and laceration to her head.

This applies to 1 of 5 residents (R1) reviewed for safety and supervision.

The findings include:

1. The Progress Notes dated 5/2/19 for R1 showed, "11:30AM - Called to resident room by certified nursing assistant (CNA); Noted resident laying on the floor on her right side under the mechanical lift; resident responsive. Noted a large pool of blood under her head. Resident transferred back to bed; ice applied to area on her forehead; 3:54PM - Ambulance transferring resident to the hospital. Right knee slightly swollen, ice in place."

The hospital Discharge Instructions dated 5/2/19 for R1 showed, "Contusion of Face, Closed Fracture of Femur, Distal End, Dementia, Laceration - Injury."

The Progress Note dated 5/2/19 for R1 showed, "10:45PM - R1 returned with an immobilizer to her right leg; Complete skin check completed. Three steri strips to right forehead."

The Physician Orders for R1 showed on 5/7/19

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and order was entered for strict nonweight bearing to the right knee with the brace locked at all times; follow up appointment in 2 weeks.

On 5/14/19 at 8:56AM, V7 (CNA Supervisor) stated, "R1 has been a mechanical lift transfer with two assist for the last two years. They told me the chair was at the foot of R1's bed and V4 (CNA) was on the resident's right side and hooked up all four straps. V3 (CNA) started to raise the mechanical lift and R1 went out the side. I would guesstimate the sling was not on there the right way and R1 fell out onto her right side." V7 stated falls from a mechanical lift can happen due to incorrect positioning of a resident, not holding onto a sling, hooks not attached correctly/completely, moving the mechanical lift to fast, mechanical lift legs not open or the sling not being the right size."

On 5/14/19 at 9:12AM, V3 (CNA) stated, "It happened so fast. V4 (CNA) checked the straps of the sling to the lift. I asked her if she was ready and she said yes. I raised the lift and the next thing I know R1 was out of the sling. I was at the front of the sling at R1's legs and she went out the right side. We think the strap (with loops) wasn't all the way back when it was put on the lift. The bottom one came undone but didn't rip."

On 5/14/19 at 9:25AM, V2 (Director of Nursing - DON) stated no one should fall out of a mechanical lift. V2 stated some reasons a resident may fall out of a mechanical lift would be improper fitting of the sling, staff error, staff rushing, improper placement of the sling and loops not secure; they need to check those."

On 5/14/19 at 10:34AM, V4 (CNA) stated when they lifted R1 up she slipped out from the side of

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the sling, landed on her elbow and hit her head. V4 stated R1 broke her right femur; doesn't know if the loop on the sling came undone and no one should ever fall out of a sling.

The Minimum Data Set (MDS) dated 3/25/19 for R1 showed a brief interview of mental status (BIMS) score of 6 which means severe cognitive impairment; extensive assist of two people for transfers.

R1's current care plan printed on 5/14/19 showed on 5/17/17 an intervention of a mechanical lift with two staff assist was entered onto the care plan.

The facilities Safe Lifting and Movement of Residents policy (4/2019) showed, "In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents. Staff responsible for direct resident care will be trained in the use of manual and mechanical lift devices."

On 5/14/19 at 8:29AM, R1 was sitting in a semi reclined wheelchair with a blanket over her lap, with her foot and part of right leg exposed and turned inward. R1 had bruises to her face and a healed cut to her forehead near the hairline. At 1:25PM R1 stated she fell but doesn't know how and stated her right leg hurts. At 1:30PM, R1's right leg was visible, had a brace on it and her foot was turned inward.

(B)