STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006985	A. BUILDING: _____ B. WING _____	04/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OTTAWA PAVILION	704 EAST GLOVER STREET OTTAWA, IL 61350

(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 Annual Licensure and Certification Survey Statement of Licensure Violations	S 000		
S9999	Final Observations Statement of Licensure Violations Section 300.610a) Section 300.610c)4)B)C) Section 300.690b) Section 300.690c) Section 300.1210d)6) Section 300.2210a) Section 300.2210b)2) 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. c) The written policies shall include, at a minimum the following provisions: 4) A policy to identify, assess, and develop strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a resident. The policy shall	S9999		

Attachment A
Statement of Licensure Violations

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S9999	Continued From page 1	S9999		

establish a process that, at a minimum, includes all of the following:
B) Education of nurses in the identification, assessment, and control of risks of injury to residents and nurses and other health care workers during resident handling;

C) Evaluation of alternative ways to reduce risks associated with resident handling, including evaluation of equipment and the environment
Section 300.690 Incidents and Accidents
b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.

c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.

Section 300.1210 General Requirements for Nursing and Personal Care
d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the

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S9999	Continued From page 2 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 300.2210 Maintenance a) Every facility shall have an effective written plan for maintenance, including sufficient staff, appropriate equipment, and adequate supplies. b) Each facility shall: 2) Maintain all electrical, signaling, mechanical, water supply, heating, fire protection, and sewage disposal systems in safe, clean and functioning condition. This shall include regular inspections of these systems These Regulations were not met as evidenced by: Based on interview and record review, the facility failed to ensure slings used for mechanical lift transfers were in good repair for one resident (R87) of nine residents reviewed for falls in the sample of 28. This failure resulted in R87 falling and sustaining a left ankle fracture. Findings include: Facility policy, Washing/Care of Mechanical Lift Slings, undated, documents "The slings are inspected by the laundry staff at the time they are washed. If a sling is frayed or appears to need repair, it is removed from use and given to the	S9999		

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S9999	Continued From page 3	S9999		

laundry supervisor or restorative supervisor."

R87's Incident Note/Nursing Note, dated 2/1/18, documents R87 continued on post fall assessment. R87's Nursing Note, dated 2/2/18, documents R87 "left the facility for an x-ray of (R87's) left ankle."

On 4/27/18 V1 Administrator provided investigation documentation for R87's fall on 2/1/18. This included documentation stating "Verbal counseling given to (V11 and V12/Certified Nursing Assistants) on checking slings for defects before transferring a resident." The investigation notes provided document on 2/1/18 "Aides state 'We just started to lift (mechanical) from wheelchair when the strap slipped.'" This investigation also documented that staff were educated on proper sling usage on 2/2/18.

R87's Physician Progress Note, dated 2/6/18, documents "(R87) non-displaced fracture of left tibia states the lift at the nursing facility broke and (R87) fell hitting (R87) feet on the floor."

On 4/27/18 at 10:49am, V11(CNA) stated that on 2-1-18 V11 and V12 hooked R87's sling to a mechanical lift and that as they began to lift it, the strap broke and R87 fell to the floor.

On 4/27/18 at 12:00pm, V20 (Licensed Practical Nurse/LPN) stated that the strap of R87's sling had broken on the top left side.

On 4/27/18 at 10:55am, V19 (CNA Coordinator/Laundry Supervisor/Housekeeping Supervisor) stated that laundry aides are responsible for examining slings for wear and tear; this is done prior to sling use by CNAs. V19

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S9999	Continued From page 4 stated that all laundry employees are given inservices on what to do if slings are worn or damaged. On 4/27/18 at 10:55am, V19 stated that the laundry staff check to see if slings are getting worn or bad or if threads are loose; old ones are discarded. V19 stated that the sling used for R87 should have been thrown out and not used by CNAs for transfers. On 4/27/18 at 10:55am, V19 stated that on 2/1/18, V18, Laundry Aide was working. V19 said that V18 informed V19 that V18 only checked the straps attached to R87's sling but did not examine the loops. On 4/27/18 at 10:40am, R87 confirmed that the staff transferred (R87) on 2/1/18 from the wheelchair to R87's bed. R87 stated the sling the staff was using was "rotten!" R87 stated "Ask the CNAs, they will tell you the same thing." R87 stated when R87 slipped R87 landed on the floor and xrays showed that R87's left ankle was fractured. (B)	S9999		