

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/07/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145259	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/03/2009
NAME OF PROVIDER OR SUPPLIER ALDEN PARK STRATHMOOR			STREET ADDRESS, CITY, STATE, ZIP CODE 5668 STRATHMOOR DRIVE ROCKFORD, IL 61107		
(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) COMPLETION DATE	
F 000	INITIAL COMMENTS	F 000			
F 323 SS=D	<p>Complaint Investigation</p> <p>#0911399 / IL40626</p> <p>No extended survey was conducted.</p> <p>483.25(h) ACCIDENTS AND SUPERVISION</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide supervision and assistance to keep a resident safe during a transfer with a mechanical lift.</p> <p>This applies to 1 resident that slid out of the mechanical lift sling. (R1)</p> <p>The example includes:</p> <p>The Physicians Order Sheet dated 3/2009 shows that R1 has diagnoses including Cerebrovascular Accident and Dementia.</p> <p>The Minimum Data Set of 1/7/09 shows that R1 is totally dependent on 2 or more staff for transfers.</p> <p>The Nurses Notes dated 3/26/09 state, "Resident</p>	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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F 323	Continued From page 1 in (mechanical lift) sling, slid out of sling. Resident head was hit on top. Ice applied to her head, bump did go down quite a bit." The facility Incident Report dated 3/26/09 states, "CNA in room transferring resident in (mechanical lift) with sling. CNA stated that when she turned the (mechanical lift)- resident started to slide out of sling. She tried to catch her but she slid down to floor. Hit her head - Large "goose egg" on top of her head." R1's care plan dated 1/4/09 states, "Resident at risk for falling related to Diagnosis of Dementia and decreased sitting balance." One approach listed for states, "Inservice staff on mechanical lift usage and appropriate pad usage." On 4/2/09 at 8:15 AM, E9 (CNA) was asked what the procedure was for transferring R1. E9 stated, "We use 2 assist. Sometimes they use a (mechanical lift). They want us to use the (mechanical Lift) because sometimes she doesn't stand very well." On 4/2/09 at 10:15 AM, E8(RN) stated, "E4(CNA) got suspended for that." On 4/2/09 at 10:20 AM, E6(LPN) stated, "E4 was in there, put her on the (mechanical lift) because she pinches. There should be 2 people and they all know that. E4 says she slipped out of it. It is the CNA's discretion if they use the (mechanical lift) or not with R1." The facility inservice dated 11/20/08 states, "Mechanical lift transfers are to be done with 2 staff members at all times."	F 323			
F 456	483.70(c)(2) SPACE AND EQUIPMENT	F 456			

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F 456 SS=D	<p>Continued From page 2</p> <p>The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure a resident shower chair was in good working order to prevent an incident causing resident (R2) distress.</p> <p>This applies to one shower chair on the E wing.</p> <p>The example includes: The facility Incident Report dated 2/26/09 states, "Resident, CNA and I were in the shower room. Resident was sitting on shower chair in shower when chair broke multiple times and resident tipped backwards in chair. No known injury. No lacerations, lesions, bruises or abrasions. Did have an anxiety attack."</p> <p>The Nurses Notes dated 2/26/09 states, "At 1400 CNA and I took resident to shower when resident sat in shower chair in the shower it broke and resident fell backwards. Resident did not hit her head and has no apparent injuries. Called available staff to shower room STAT and RT(respiratory therapy) STAT to assist with getting resident to safe location. With assist of 5 other staff, resident in stable wheelchair. Resident had anxiety attack. PRN medication given."</p> <p>On 4/2/09 at 9:45 AM, R2 was observed sitting in a chair in her room. R2 is an obese lady that is dependent on a ventilator for breathing. R2 was</p>	F 456			

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F 456	<p>Continued From page 3</p> <p>asked if she was injured during the incident. R2 shook her head no. R2 asked if the incident scared her. R2 nodded her head yes."</p> <p>On 4/2/09 at 9:55 AM, E8 (RN) stated, "Oh, what a mess! Respiratory was called STAT to the shower room so I went running too. R2 was on her back with her feet up in the air. I assume the chair had some weak stress points. The bottom back joint cracked. She had redness on her back and she was very anxious. PRN medications were given. It had to be a harrowing experience!"</p> <p>On 4/2/09 at 10:00 AM, E5 (Maintenance) stated, "The shower chair is in the basement. I kept it because of this incident." E5 went to the basement to find the shower chair, returned and stated, "It is gone- someone must have thrown it out. The PVC pipe holding the caster cracked and the caster went down. I attribute it to the old age of the chair." E5 was asked if he did any routine maintenance on the shower chairs. E5 stated, "I don't do anything routine but I change the casters on those things all the time due to the casters rusting with the use in shower. It probably could have been prevented with routine maintenance, if I had known."</p>	F 456			