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S 000	Initial Comments Statement of Licensure Violations Complaint Investigations 1813814/IL103338 1813870/IL103400 1813898/IL103424	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 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.	S9999	Attachment A Statement of Licensure Violations	

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Section 300.1210 General Requirements for Nursing and Personal Care

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.

Thest Regulations were not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure staff safely transferred R1 while using a mechanical lift with sling. The facility failed to have a system in place to ensure facility staff transferred R1 using the appropriate sling size based on resident

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assessment. The sling disconnected from the mechanical lift causing R1 to fall to the ground on June 12, 2018. R1's fall resulted in R1 sustaining a subdural hematoma, two spinal fractures, and was subsequently hospitalized.

This applies to 1 of 3 residents (R1) reviewed for mechanical lift transfers in the sample of 3.

The findings include:

R1's Electronic Medical Record shows R1 was admitted to the facility on March 12, 2015 with diagnoses including: End stage renal disease, diabetes mellitus, legal blindness, and hemiplegia. R1's progress note dated June 12, 2018 at 6:32 AM shows "a CNA (Certified Nursing Assistant) and (V4)-RN (Registered Nurse) were moving (R1) from R1's bed to R1's chair with the mechanical lift when the sling came undone. (R1) complained of hitting R1's head on the floor and a slight headache. Tylenol given for headache. Family, doctor, and DON (Director of Nursing) notified of incident." A nursing note dated June 12, 2018, at 1:52 PM, signed by V7 LPN (Licensed Practical Nurse) shows, "before lunch (R1) complained of slight pain to right side of temple, Tylenol provided. After lunch (R1) was transferred back to R1's bed and then complained of pain behind her right shoulder. Daughter was present at the time and requested for R1 to be sent to the emergency room for evaluation."

On June 14, 2018 at 2:41 PM, V3 (R1's daughter/Power of Attorney) stated, "(V4) called me last Tuesday (June 12, 2018) at 6:56 AM and said V4 dropped my mother. V4 told me the mechanical lift sling was too big and (R1) was

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complaining of a headache. I got to the facility at 1:30 PM. My mother was crying I requested she be sent to the hospital for evaluation."

On June 19, 2018 at 10:10 AM, R1 was interviewed at a different local nursing facility. During the time of R1's interview, she was lying in bed and was able to tell this surveyor what day it was, where she was at, what part of the month it was, and what year it currently was. When the incident was discussed regarding R1's fall at the previous nursing facility, R1 became tearful and stated she had back pain due to this fall. "There was a new girl and a man that lifted me up in the mechanical lift. My head and back hit the floor. It happened early in the morning. The back of my head hit first, and I got right eye pain. When I hit the ground, there was a flash of bright blue light. My legs were still in the sling. I thought they were going to send me to the hospital in the morning when it happened. My pain increased as the day went on. Now, it hurts me to move. I am afraid of the mechanical lift, I do not want to be transferred by the mechanical lift." (Resident crying more heavily during this statement)

On June 18 2018 at 5:05 AM, V4 stated "The agency CNA (V5) and I transferred R1 using the mechanical lift. V5 was not familiar with the mechanical lift. One of the sling attachments popped off and (R1) slid out butt first. (R1) told me R1 hit R1's head on the ground and R1 said R1 had a headache. I gave R1 Tylenol. I notified the doctor on call and he said just to monitor R1. I called (R1's) daughter (V3) and she questioned sending (R1) out (to the hospital for evaluation). I told her R1 was doing well. We used the orange sling to transfer her." On June 19, 2018 at 12:05 PM, V4 stated, "(V5) had no clue on how to use the mechanical lift. The orange sling seemed big

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when (R1) was in it. The other CNAs have been wrapping the bottom part of the sling around the mechanical lift bar-probably because of the size of the sling. I did not check the connection of the sling before we lifted (R1) with the mechanical lift."

On June 18, 2018 at 12:15 PM, V5 stated, "V4 and I were transferring R1 with the mechanical lift. V4 said to me, 'The sling is too big. You have to wrap it around the mechanical lift bar then snap it because it makes it stronger.'" V5 said R1 was scared while R1 was in the sling and was holding onto the bar so they had to instruct R1 to let go. V5 stated, "The top part of the sling fell off of the mechanical lift and (R1) fell hard on R1's head, R1'S feet and butt were still in the sling. R1 said R1 was in pain. I was trying to console R1." V5 completed a CNA Post Fall Investigation Form on June 12, 2018. V5 indicated that using a smaller lift-sling could help this resident from falling again.

On June 19, 2018 at 8:55 AM, V6 CNA said she didn't know what happened to R1. She just helped get R1 off the ground. "She (R1) said R1's head hurt. (R1) never complained of pain in R1's head before."

On June 18, 2018 at 12:45 PM, V7 LPN (Licensed Practical Nurse) stated, "I was the nurse that came on after (R1's) fall. (V4) told me (R1) had fallen and that one side of the sling came undone and (R1) hit the back of R1's head. After lunch, (R1) said R1 had a headache so I gave R1 Tylenol. The CNAs transferred her into bed and (R1) complained of pain in her back. (V3) (R1's daughter) told me that she told (V2) DON (Director of Nursing) to send (R1) out for evaluation."

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On June 18, 2018 at 10:25 AM, V8 CNA said on June 12, 2018 she was given report that R1 fell on R1's head. "It was an agency CNA that was taking care of her. I saw the orange sling in R1's room and I knew it was too big. The orange sling is meant for bigger people. The green or blue sling is used for (R1). Sometimes the blue or green sling gets soiled, so we have to use the orange sling. We have to wrap the sling multiple times around the bar so it fits." At 12:35 PM, V8 said it is important to use the correct sling so that no one slips.

On June 18, 2018, at 6:10 AM, V2 (DON) stated, "(V4) called on June 12, 2018. He reported (R1) had fallen. (V4) said the one side of the sling had came undone. V4 told me it was the top part that came undone. (V4) told me (R1) fell on R1's right shoulder and hit R1's head. (V4) gave (R1) Tylenol for a headache. Around lunch time (R1) stated the headache was worsening and R1 was sent out for evaluation. (R1) has a small acute subdural hematoma on the right side (brain bleed) and L2 and L3 fractures on the right side (Lower back fractures). I believe they were using an orange sling when R1 fell. There is a list of what color sling to use in the resident's closet."

R1's emergency room provider progress notes dated June 12, 2018 at 3:14 PM, shows, "(R1) reported R1 was dropped out of a mechanical lift today. Paramedic reports that the patient did not fall completely out of the lift that R1's lower body was still in the lift at the time of the fall. (R1) was complaining of pain to R1's right head, face, right shoulder and right lumbar (lower back). (R1's) radiology report dated June 12, 2018, at 4:11 PM, shows a subdural hematoma that measured 4mm by 5 mm and 6 mm thick and there are fractures

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of the right L2 and L3 transverse processes."

R1's "Life/Movement Profile Assessment" dated June 15, 2017 completed by V9 CNA shows R1 should be transferred using a blue sling. On June 19, 2018, at 12:50 PM, V9 said V9 assesses for sling size by measuring from the butt to the head and as long as the sling covers this then this is the appropriate size.

On June 19, 2018, a sling inventory list was provided by the facility, it shows there are two orange slings and two blue slings in the facility. V2 provided a census list on which she indicated four residents currently in the facility use blue slings (R2, R3, R4, R5). R2-R5 resided in the facility on June 12, 2018 when R1 fell from the mechanical lift. (5 residents residing in the facility that required blue slings and the facility had 4 slings available.)

On June 18, 2018, at 1:25 PM, V2 stated, "If the sling is too big the resident's can hang and that makes it unstable. Mechanical lift slings should not be wrapped around the bar, that is not procedure, it can come undone."

On June 20, 2018, at 8:50 AM, V2 stated, "Sometimes the residents have to share slings. If slings are unavailable due to soiling unfortunately the residents have to wait. Staff are not supposed to use different slings. I was not aware they were using different colored slings. Staff has said sometimes they can't find the appropriate sling. If staff did not use the right sling that could explain why the hook came off."

On June 19, 2018, at 1:10 PM, in the presence of V1 Administrator and V2 DON, measurements were taken of an orange sling and a blue sling for

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comparison. The orange sling measured 41 inches from the top of the sling where the residents head should lie to the bottom of the sling where the resident's buttocks should be. The same area measured on the blue sling was 36 inches. The orange sling measured 46 1/2 inches wide and the blue sling measured 41 inches wide. The orange sling from where the resident's buttocks would be to the part of the sling that would hook up to the mechanical lift and hold up the resident's legs measures 37 1/2 inches long and the same measurement on the blue sling is 28 1/2 inches long. V1 and V2 confirmed these measurements.

The manufacturer's guide for the mechanical lift slings dated October 2014 shows, "WARNING, to avoid the resident from falling, make sure to select the correct sling size and make sure that the sling attachments are attached securely before and during the lifting process." The manufacturers instructions for use for the mechanical lift dated June 2013 shows, "CAUTION: Always check that all the sling attachment clips are fully in position before and during lifting cycle and in tension as the patient's weight is gradually taken up and a blue sling is an extra large and a terracotta (orange) sling is an extra extra large.

R1's care plan dated October 1, 2017 shows R1 uses a mechanical lift for transfers as appropriate and does not include which color sling to use.

The facility's policy on Safe Patient/Resident Handling and Movement revises on June 6, 2017 shows, "staff should utilize the proper techniques, lifting devices, etc. to match the identified talk. No associate should engage in any work and activity that they believe would/could cause harm or

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S9999	Continued From page 8 injury to themselves and or others. Associates should recognize the unsafe behavior and provide immediate instruction or assistance to co-workers or if needed report these issues to the charge/team leader/manager using the chain of command as needed. (A)	S9999		