STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009302	A. BUILDING: _____ B. WING _____	C 03/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOME	418 WASHINGTON STREET QUINCY, IL 62301

(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 Complaint 1921707/IL110223 Statement of licensure violations	S 000		
S9999	Final Observations 300.1210b) 300.1210d)6) 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 resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: 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. These requirements were not met as evidenced by:	S9999	**Attachment A** **Statement of Licensure Violations**	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Electronically Signed — 04/05/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 1	S9999		

Based on observation, record review, and interview, the facility failed to ensure resident safety during repositioning for one of three residents (R1) reviewed for injuries in a sample of three.
This failure resulted in a bruising and a laceration to a lower extremity which required suturing in a local Emergency Department.

Findings include:

R1's MDS (Minimum Data Set) assessment dated 12/19/18 documents R1 has short and long term memory problems and is moderately cognitively impaired. R1's current care plan accessed electronically on 3/15/19 indicates R1 is totally dependent on staff for bed mobility, transfers, dressing, toileting, personal hygiene, and movement about the facility.

A facility report to the State Agency documents on 3/11/19 at approximately 8:00 a.m. R1 sustained a large laceration to R1's right lower leg and was sent to the local Emergency Room for treatment. A Resident Abuse Investigation Report Form completed by V5 (RN - Registered Nurse/Unit Coordinator) states, "(R1) moved her legs and they were covered up by a blanket. When staff attempted to sit (R1) up properly (for meal service) (R1's) leg was in the wrong spot and sustained a laceration."

On 3/19/19 at 8:40 a.m., V6 (CNA - Certified Nursing Assistant) stated, "The nurse asked for a chair for (R1) to keep (R1's) feet from coming out. (R1) was scooting down in the chair too. I got (R1) a wide recliner (geri chair) out of the storage room about three weeks to a month before (R1's 3/11/19 injury). (R1) sat on a (air) cushion and (non-slip sheet of material) to keep

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S9999	Continued From page 2	S9999		

(R1) from sliding. We mainly kept (R1) reclined. It (R1's geri chair) was hard to recline up to a sitting position. I couldn't get it to sit up. I tried one, two, maybe three times and I couldn't get it to sit up. (V7 LPN - Licensed Practical Nurse) was in the dining room serving drinks and I asked (V7 LPN) to help me. (R1) had a blanket over (R1's) legs so you couldn't see her legs. I went out of the dining room to bring up another resident and when I got back there (V7 LPN) did get it (geri chair) out of the reclining position and another resident said there was blood on the floor. (R1) didn't yell or say anything and didn't act like (R1) was in pain. (R1) didn't even say anything when the paramedics got there. (R1) has dementia and once in a while will say something but really doesn't have conversation. When I got back to the dining room, the blanket (covering R1's legs) was in place. (R1) was reclined back at some point. I don't really remember when. It was an awful gash (the laceration to R1's right lower leg). I ran and got bath towels and we (V6 CNA and V7 LPN) wrapped it up tight. I regret that both of us (V6 CNA and V7 LPN) should have removed the blanket (over R1's legs) to see where (R1's) legs were. I didn't see (R1) get her legs off of (R1's geri chair)."

On 3/19/19 at 12:48 p.m., V7 (LPN) stated, "I was in the dining room setting up drinks and breakfast and (V6 CNA) was having trouble getting (R1's) chair up (from a reclining position). I didn't see (V6 CNA) trying but (V6) asked if I could help. I was busy at the time and (V6) left the room. I don't know if I acknowledged (V6) but I think I told (V6) I would help. After (V6) left I tried and the first time it (R1's geri chair) didn't go up but the second time it did. It was a little difficult, the chair was older. Then I pushed (R1) toward the table

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and another resident alerted me to there being blood on the floor. (R1) had a blanket on (R1's) legs. I came up from behind (R1) to put the (geri) chair up (from reclining to sitting position). (R1) had a wound to her (right lower) leg. It was a gaping wound. We applied pressure with towels and pulling it together. (R1's) leg was obviously pinned behind the foot rest and the metal part of the geri chair."

On 3/19/19 at 3:55 p.m., V5 (RN-Unit Coordinator) presented a blue colored Geri chair parked near the elevator in a nearby empty unit as the Geri chair R1 was using when injured on 3/11/19. The mechanism to raise or lower the foot rest is a notch and peg bar that has to be kicked off of the peg located on the Geri chair frame before the footrest can be raised or folded up under the Geri chair seat.

On 3/19/19 at 3:30 p.m., V5 (RN Registered Nurse-Unit Coordinator) stated, "(Staff) shouted 'Bleeding come quick!' (V14 LPN) took off and responded to help. (V14 LPN) was the one that wrapped R1's leg in towels to get it to stop bleeding. I didn't get to see (R1's) leg until they brought (R1) up to me (at the nurses' station). It had stopped bleeding by then. I looked at it and rewrapped it. The wound was gaping. I applied pressure and redressed it. I thought at first something may have been wrong with the chair, but looking at the chair I didn't see blood on it. I couldn't figure out what caused it unless (R1) had got (R1') leg caught in between (the chair and the foot rest)."

On 3/19/19 at 4:00 p.m., V14 (LPN) stated, "They called for help. When I got there, there was blood on the floor. (R1's) foot rest was down. (V7 LPN) was in there (the dining room) and a

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S9999	Continued From page 4	S9999		

CNA was there but I don't remember who. We weren't sure at first what happened. I used the towels to help stop the bleeding."

A hospital Transfer Report Form dated 3/11/19 states, "In geri chair, cut to right leg on chair, unable to control bleeding." A Emergency Room Note dated 3/11/19 states, "Large, 20 cm full thickness laceration to medial right lower (right) extremity." A hospital Procedure Note dated 3/11/19 states, "Closure was achieved with 20 sutures." R1's 3/11/19 hospital discharge orders state, "Keep clean with topical antibiotic ointment and daily dressing changes. Suture removal 10 to 14 days."

On 3/15/19 at 2:09 p.m., R1 was lying in bed making no verbal response or eye contact with care givers, V11 (LPN - Licensed Practical Nurse) and V12 (RN- Registered Nurse) who were present to perform R1's wound treatment. V11 (LPN) removed R1's right lower leg dressing. R1 had 20 largely spaced (1 to 1.5 centimeter (cm) in width joining the wound together and approximated 1 cm apart along the length of the wound) sutures in a wide v-shaped wound which covered R1's lower right leg. R1's wound also had dark purple bruising from the center of the wound toward the distal edges of the wound.

(B)