Illinois Department of Public Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6011589 | A. BUILDING: _____ B. WING _____ | C 09/19/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SOUTH HOLLAND MANOR HTH & RHB | 2145 EAST 170TH STREET SOUTH HOLLAND, IL 60473 |

| (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<br><br>Complaint Investigation<br><br>1995995/IL114873 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations<br><br>300.1210b)<br>300.1210d)6)<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br>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:<br><br>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:<br><br>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. | S9999 | **Attachment A**<br>**Statement of Licensure Violations** | |

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| S9999 | Continued From page 1 | S9999 | | |

These requirements were not met as evidenced by:

Based on interview and record review the facility failed to use a footrest while transporting a resident in a wheelchair for 1 of 4 residents (R1) in a total sample of 4. This failure resulted in R1 hitting the left ankle on the bedframe while being transported and sustaining a left ankle fracture.

Findings Include:

The Face Sheet documents that R1 was admitted to the facility on 8/21/17 with a diagnosis of Dementia and the resident requires assistance with all activities of daily living.

The Incident Report dated 7/11/19 documents that V6 (CNA) was pushing the resident in the wheelchair when R1's ankle twisted. R1 had complaints of pain and an x-ray was done that showed a displaced fracture of the left ankle. The Physician was notified and R1 was transferred to the local hospital for evaluation.

On 7/11/19 an investigation was done and V6 stated that R1 was being pushed in the wheelchair so that the resident could be taken out of the room. R1 then complained of ankle pain. V6 observed that the resident's foot was not on the footrest of the wheelchair. IDPH was notified of the incident and V6 was terminated from the facility for not using a footrest while pushing a resident in a wheelchair.

The radiology report dated 7/11/19 shows an acute fracture involving left distal fibula and distal tibia with minimal displacement.

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| S9999 | Continued From page 2<br><br>The Hospital records dated 7/11/19 documents that R1 presented with complaints of left ankle pain. Family states that the resident was put into a chair and hit the left ankle on the bed. No other injuries noted. X-ray shows acute fracture involving left distal fibula and tibia with associated soft tissue swelling. R1's leg immobilized with a splint and the resident was referred for an orthopedic consult.<br><br>The Orthopedic Consult dated 7/18/19 documents that R1 should wear an ankle immobilizer during transfers related to the left ankle fracture.<br><br>On 9/18/19 at 1:25pm V2 (Director of Nursing/DON) stated "V6 walked in to get the resident up out of bed. V6 got the resident up in the wheelchair and did not put the footrests in place. V6 was rolling the resident out of the room when R1's foot hit the bottom of the roommates' bed. R1 yelled 'Ouch' and V6 saw what happened and got the resident back in bed. We got an x-ray done that showed a fracture of the ankle and the resident was sent out to the hospital. The family refused surgical intervention so the resident now wears a boot at night. V6 got the resident up with no problem but forgot to put the footrest in place. The resident should have had a footrest for safety because the resident was being pushed in the wheelchair. V6 was terminated because the footrest was not used. Footrests were not documented on the care plan at the time. The care plan has been updated to include using footrests when the resident is being pushed in the wheelchair. All residents are now assessed for footrests on admission."<br><br>(B) | S9999 | | |

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