STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009567	A. BUILDING: _____ B. WING _____	C 01/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDENVIEW MANOR	14792 CATLIN TILTON ROAD DANVILLE, IL 61834

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S 000	Initial Comments Complaint #2060089/IL118907	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 d)6) 300.1220 b)3) 300.1220 b)8) 300.3240 a) 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. 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	S9999	**Attachment A** **Statement of Licensure Violations**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009567	A. BUILDING: _____ B. WING _____	C 01/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDENVIEW MANOR	14792 CATLIN TILTON ROAD DANVILLE, IL 61834

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S9999	Continued From page 1	S9999		

resident to meet the total nursing and personal care needs of the resident.

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 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

8) Supervising and overseeing in-service education, embracing orientation, skill training, and on-going education for all personnel and covering all aspects of resident care and programming. The educational program shall include training and practice in activities and restorative/rehabilitative nursing techniques through out-of-facility or in-facility training programs. This person may conduct these

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDENVIEW MANOR	14792 CATLIN TILTON ROAD DANVILLE, IL 61834

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S9999	Continued From page 2	S9999		

programs personally or see that they are carried out.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These requirements are not met as evidenced by:

A. Based on observation, interview, and record review, the facility failed to follow manufacturer's guidelines during a full mechanical lift transfer for two of three residents (R1, R6) reviewed for mechanical lift transfers , and failed to investigate falls and implement post fall interventions for one resident of three (R7) reviewed for falls with injury in the sample list of nine. These failures resulted in R1 falling and sustaining a left hip fracture.

Findings include:

1.) R1's Face Sheet, dated 1/7/20, documents R1 has a diagnosis of Morbid Obesity.

R1's Minimum Data Set, dated 9/7/19, documents R1 is cognitively intact and is totally dependent with assitance of two staff for transfers.

R1's Care Plan, revised on 12/30/19, documents R1 is at risk for falls with interventions dated 11/1/17 to assure R1's floor is free of glare, liquids, and foreign objects and to provide an environment "free of clutter." This Care Plan documents to "assist with transfers daily and as needed" but does not identify how R1 transfers.

R1's fall investigation, dated 1/1/20, documents R1 had a fall during a transfer and was sent to the Emergency Room. This investigation

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	IL6009567	A. BUILDING _____ B. WING _____	C 01/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDENVIEW MANOR	14792 CATLIN TILTON ROAD DANVILLE, IL 61834

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S9999	Continued From page 3	S9999		

documents V3's statement, dated 1/2/20, on 1/1/20, V3 assisted V8 with transferring R1 from R1's bed to wheelchair. This statement documents R1 was raised in the air suspended in the lift when V8 turned to move bags out of the way, and R1 "began moving which caused lift to tip over." V8's undated written statement documents R1 began rocking in the mechanical lift and the lift tipped over. This investigation does not document the root cause of R1's fall.

R1's Hospital History and Physical Note, dated 1/1/20, and signed by V19, Advanced Practice Nurse, documents R1 was admitted on 1/1/20 for head, left hip, knee, and leg pain post fall from a full mechanical lift at a nursing home. This note documents R1's diagnoses including Head Contusion and Left Hip Fracture Secondary to fall.

R1's X-Ray report of the left hip and pelvis, dated 1/1/20, and signed by V18, Medical Doctor, documents "Impression: Acute comminuted fracture deformity noted at the junction of left greater trochanter and upper shaft of the left femur. There is also acute fracture of the left greater trochanter. There is displacement of fracture fragments with deformity."

R1's Progress Note, dated 1/2/20 at 2:40 PM, by V12, LPN (Licensed Practical Nurse), documents V12 heard yelling from R1's room. Upon entering R1's room, V12 observed the full mechanical lift was tipped over on its side with R1 on the floor in the mechanical lift sling. R1 was lying on R1's left side with R1's head against a wooden bench. R1 complained of head and left hip pain.

R1's Progress Note, dated 1/2/20 at 2:45 PM, by V12, LPN, documents R1 complained of left hip

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 4	S9999		

pain and was sent to the Emergency Room for evaluation.

On 1/7/20 at 11:10 AM, R1 stated on 1/1/20, V8, CNA (Certified Nursing Assistant), and another unidentified CNA (V3) were transferring R1 with a full mechanical lift from the bed to R1's wheelchair. R1 stated the mechanical lift tipped over causing R1 to fall to the floor. R1 stated R1 hit R1's head on a wooden bench and the mechanical lift fell on top of R1. R1 stated R1 was admitted to the hospital with a broken hip that required surgery.

On 1/7/20 at 3:32 PM, V3, CNA ,stated on 1/1/20, V3 and V8 were transferring R1 with a full mechanical lift from the bed to the wheelchair. V3 stated R1 was suspended in the air above the bed, V3 pulled the mechanical lift away from the bed, and V8 let go of R1 to move bags and linens on the floor out of the way. V3 stated V3 began pulling the lift and R1 started swaying back and forth in the mechanical lift sling causing the mechanical lift to tip over. R1 fell to the floor and the mechanical lift fell on top of R1. V3 stated if the bags and linens were not on the floor, V8 would not have let go of holding onto the lift sling, which would have stabilized R1's weight during the transfer, and prevented R1's fall. On 1/8/20 at 9:07 AM, V3 stated on 1/1/20, during the transfer prior to R1's fall, R1 was suspended in the air away from the bed, with R1's legs positioned together on the same side, out to the side of the lift. V3 stated V3 was unable to recall what size mechanical lift sling was being used for R1 during the transfer, and V3 was unsure how to determine what size sling is to be used for R1.

On 1/8/20 at 10:50 AM, V17, R1's Orthopedic Surgeon, stated this type of fracture is consistent

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	IL6009567	A. BUILDING: _____ B. WING _____	C 01/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDENVIEW MANOR	14792 CATLIN TILTON ROAD DANVILLE, IL 61834

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S9999	Continued From page 5	S9999		

with falling from a mechanical lift.

On 1/8/20 at 11:58 AM, V1, Administrator, stated that during R1's mechanical lift transfer, R1's legs should have been positioned on each side of the mast of the lift. V1 acknowledged that R1's legs being positioned together, out to the side while being suspended in the air, could have caused R1's weight to be unevenly distributed and shift during the movement of the full mechanical lift. V1 stated V1 would expect the manufacturer's guidelines to be followed during full mechanical lift transfers. V1 acknowledged that using the incorrect size of mechanical lift sling could contribute to uneven weight distribution.

On 1/8/20 at 12:30 PM, V1 stated V1 was unable to locate any training or competencies that had been completed with staff on the use of the full mechanical lift. V1 stated the facility does not currently have a protocol in place to determine what size of mechanical lift sling is to be used for each resident

The (mechanical lift) User Manual, dated 2018, documents to thoroughly read the instructions provided in the use manual, observe trained experts perform the lifting procedures and perform the lift procedure several times with proper supervision. This manual documents during lifting/moving the patient: raise the patient high enough to clear the bed, move the lift away from the bed, turn the patient so that the patient is facing the operator of the lift while moving the lift away from the bed, and then lower the patient until the patient's legs straddle the mast and the feet rest on the base of the patient lift. This manual documents "The lower center of gravity provides stability making the patient feel more secure and the lift easier to move." This manual

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009567	A. BUILDING: _____ B. WING _____	C 01/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDENVIEW MANOR	14792 CATLIN TILTON ROAD DANVILLE, IL 61834

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S9999	Continued From page 6	S9999		

documents a warning that during lifting and transferring the patient, the legs of the lift must be in the maximum open position for "optimum stability and safety." This policy documents "If it is necessary to close the legs of the lift to maneuver the lift under a bed, close the legs of the lift only as long as it takes to position the lift over the patient and lift the patient off of the surface of the bed. When the legs of the lift are no longer under the bed, return the legs of the lift to the maximum open position and lock the shifter handle immediately."

The facility's undated Transfers and Lifts policy and procedure documents for transfer and lifting equipment staff must have training on how to use any equipment before using for the first time. This policy also documents to use the equipment as it is designed to be used, safely, with attention, and with good body mechanics.

2.) R6's Face Sheet, dated 1/8/20, documents R6 has a diagnosis of Flaccid Hemiplegia affecting the right side.

R6's Care Plan, revised on 11/12/19, documents R6 transfers with a full mechanical lift and two staff.

On 1/8/20 at 9:32 AM, V13 and V14, CNAs, transferred R6 with a full mechanical lift from the bed into the wheelchair. R6 was suspended in the air in the lift with R6's legs positioned together out to the side of the lift frame. R6's legs were not on each side of the mast of the lift. V14 pulled the mechanical lift away from the bed and towards R6's wheelchair with the legs of the lift in the closed position and R6's legs positioned together on the outside of the lift frame.

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GARDENVIEW MANOR	14792 CATLIN TILTON ROAD DANVILLE, IL 61834

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S9999	Continued From page 7	S9999		

On 1/8/20 at 9:38 AM ,V13 and V14 stated they have not received any training on the use of the full mechanical lift. V13 stated V13 usually keeps the legs of the lift closed during the transfer and V13 doesn't position the legs of the lift in the wide position until approaching the wheelchair. V14 confirmed that during the transfer, R6's legs were not positioned on each side of the mast of the lift. V14 stated R6 has difficulty moving R6's legs apart.

On 1/8/20 at 11:58 AM, V1 stated V1 would expect the manufacturer's guidelines to be followed during full mechanical lift transfers. On 1/8/20 at 12:30 PM, V1 stated V1 was unable to locate any training or competencies that was completed with staff on the use of the full mechanical lift.

3.) R7's Face Sheet, dated 1/7/20, documents R7's diagnoses including Dementia with Behavioral Disturbances and Parkinson's Disease.

R7's Minimum Data Set, dated 10/2/19, documents R7 requires extensive assistance of one staff member for transfers.

R7's Progress Note, dated 10/14/19 at 10:05 PM, by V12, LPN (Licensed Practical Nurse), documents R7 was asleep in R7's room and "slid out" of R7's wheelchair. R7's Progress Note, dated 10/15/19 at 10:10 PM, by V12, documents R7 was in R7's room and "slid out" of R7's wheelchair. There is no documentation in R7's medical record of post fall interventions for R7's falls on 10/14/19 and 10/15/19.

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GARDENVIEW MANOR	14792 CATLIN TILTON ROAD DANVILLE, IL 61834

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S9999	Continued From page 8	S9999		

R7's Progress Note, dated 10/16/19 at 11:57 PM, by V12, LPN, documents R7 needs a pommel cushion or nonskid device in R7's wheelchair.

R7's Progress Note, dated 10/28/19 at 11:26 PM, by V12, LPN, documents at 8:20 PM, R7 had slid out of R7's wheelchair landing on R7's left arm on the floor. This note documents R7 hit R7's head on the floor and had a two inch skin tear to R7's hand. R7 was transferred by ambulance to the local emergency room for evaluation. R7's Progress Note, dated 10/29/19 at 3:00 AM, by V12, documents R7 returned to the facility and R7 received sutures to R7's right hand at the hospital.

R7's Progress Note, dated 10/29/19 at 11:48 PM, by V12, LPN, documents a nonskid device was applied to R7's wheelchair and a fall mat was placed next to R7's bed.

R7's Progress Note, dated 10/30/19 at 6:18 PM, by V5, Registered Nurse, documents interventions including a cushion in chair was in place.

The Final Report, dated 11/1/19, for R7's fall with injury on 10/28/19, documents an intervention to assist R7 to bed between 8:00 PM and 9:00 PM so R7 will not fall asleep in R7's wheelchair.

R7's Care Plan, revised on 11/21/19, documents "Category: Falls" with two interventions, one dated 7/29/19 to refer to Restorative for a program or therapy, and the other dated 10/2/18 to educate R7 on using the call light. There are no post fall interventions documented on R7's Care Plan for R7's falls on 10/14/19, 10/15/19, and 10/28/19. R7's Care Plan does not document the use of a nonskid device, pommel cushion, or

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S9999	Continued From page 9	S9999		

floor mat.

On 1/7/20 at 2:23 PM, V20 and V21, CNAs, entered R7's room. V21 transferred R7 from the wheelchair to the bed. R7's wheelchair did not have a cushion or nonskid device in place.

On 1/8/20 at 10:55 AM, V2, Director of Nursing, stated V2 was unable to locate fall investigations for R7's falls on 10/14/19 and 10/15/19. V2 confirmed there were no post fall interventions implemented for R7's falls on 10/14/19 and 10/15/19.

On 1/8/20 at 11:58 AM, R7 was sitting in a wheelchair near the front entrance. A towel was positioned under R7, and R7 was not sitting on a cushion. At 1:11 PM, V21, CNA, confirmed R7's wheelchair did not have a cushion or nonskid device in place.

On 1/8/20 at 12:10 PM, V12, LPN, stated R7 would frequently fall asleep in R7's wheelchair and that was the cause of R7's falls on 10/14/19, 10/15/29, and 10/28/19. V12 stated R7 needed a pommel cushion in R7's wheelchair to prevent R7 from falling out of R7's wheelchair. V12 stated V12 placed a nonskid device in R7's wheelchair after R7's fall on 10/28/19 and R7 should still have the nonskid device in place.

The facility's Assessing Falls and Their Causes policy, revised March 2018, documents begin to try and identify possible causes of a fall within 24 hours of the fall. Consider chains of events or circumstances preceding a fall; including time of day the fall occurred, what the resident was doing prior to the fall, environmental factors, and whether there is a pattern of falls for the resident. This policy documents to continue to collect and

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	IL6009567	A. BUILDING: _____ B. WING _____	C 01/08/2020

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GARDENVIEW MANOR	14792 CATLIN TILTON ROAD DANVILLE, IL 61834

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S9999	Continued From page 10 evaluate information to identify the cause of the fall or determine that the cause cannot be found. This policy documents appropriate interventions to prevent future falls should be documented in the resident's medical record. (A)	S9999		