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
	IL6004501	A. BUILDING: _____ B. WING _____	10/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HITZ MEMORIAL HOME	201 BELLE STREET, P O BOX 79 ALHAMBRA, IL 62001

(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
S9999	Final Observations Statement of Licensure Violation: 1 of 1 Violation 300.1210b)5) 300.1210d)6) 300.3240a) 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. 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. (A, B) (Section 2-107 of the Act) These Requirements are not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide safe transfers and supervision to prevent falls for 3 of 7 residents (R25, R36, R38)) reviewed for falls in the sample of 21. This failure resulted in R25's fall from the full mechanical lift during which she sustained a left lower knee hematoma that subsequently resulted in an abscess resulting in permanent deformity to her left lower knee. Findings Include: 1. R25's Fall Risk Assessment, dated 12/4/18, documents R25 having confusion, chairbound, and having a score of 10, indicating the resident "should be considered at HIGH RISK for potential falls." The Facility Fall Log, dated 3/2/19, documents R25 sustained a fall that resulted in "Bruising to LLE (left lower extremity) and LUE (left upper	S9999		

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extremity)."

R25's Care Plan, onset date of 10/30/17, documents R25 requiring staff assistance to perform Activities of Daily Living (ADLs) related to Alzheimer's Disease, functional quadriplegia, and weakness as evidenced by requiring total assistance. The Care Plan further documents R25 requiring a full mechanical lift for all transfers. The Care Plan has no documentation of R25's fall incident of 3/2/19, nor any interventions related to the fall.

Incident Report, dated 3/2/19, documents R25 having sustained a fall. The description of the fall was "slid out of (full mechanical lift) sling during transfer." Interventions listed were, "Staff re-education on transfer procedures, (full mechanical) lift safety, and use of proper sling size." The Report also documents the "Root Cause Analysis. (Full Mechanical Lift) sling noted to be improper fit for resident. Sling unable to distribute resident weight effectively causing resident (R25) to fall out." The Incident Report for R25 further documents, Transferring from bed to (high back) chair, Missed Chair and Contributing Factors (Full Mechanical) sling too small.

Nursing Progress Note, dated 3/2/19 at 5:30 AM, documents that a Certified Nursing Assistant (CNA) "reported that resident (R25) slid out of the (full mechanical lift) sling during a transfer. Noted as lying on left side of floor. Transferred back to bed x (times) 3 staff and (full mechanical lift)."

Nursing Progress Note, dated 3/2/19 at 5:39 AM, documents, "Massive bruising and swelling over almost the entire lateral aspect of the left lower extremity. Large 5 inch by 8 inch bruise over the

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lateral aspect of the left upper arm. Bruise on right index finger."

Facsimile (Fax), dated 3/5/19 (un-timed), documents V15, Medical Director (MD), was notified of the following, "On top of hematoma to LLE is developing a fluid filled water blister 5 x (by) 3 cm. LLE swollen tight shiny slightly warm to touch. Please advise." Fax further documents V15, MD, ordered Keflex, 500 mg, three times daily for five days for "presumed cellulitis."

Nursing Progress Note dated 3/6/19 at 12:29 PM, documents, "(R25) LLE remains tight, shiny, blister remains intact on hematoma."

Wound management consultant progress note/wound assessment dated April, 2019, documents R25 was seen for an initial evaluation of wound to left lateral knee. The progress note also documents R25 having "erythema and swelling," measuring 5.5 cm (centimeters) (length) x 5.0 cm (width) x 4.0 cm in depth. The Wound assessment further documents "Undermining: 12 to 12 o'clock, Periwound: Abnormal erythema, Exudate: Large Amount blood (sic), Signs and Symptoms of Infection: Erythema, Odor, Warmth."

Physician Order dated 4/3/19 at 12:31 PM, documents "Ceftriaxone Sodium 1 GM (gram) Solution Reconstituted. Inject 1 gram IM (intramuscular) x 5 days. Diagnosis: Other early complications of trauma."

Physician Order dated 4/3/19 at 1:01 PM, documents "Irrigate abscess to left lateral lower leg with sterile water and a piston syringe. Fill in with a wet-to-dry dressing soaked with sterile water. Cover with 4 x (by) 4s. Wrap with kling.

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Change BID (twice daily) and prn (as needed)."

Nursing Progress Note dated 4/3/19 at 12:43 PM, documents in part, "(R25) area to LLE -lateral aspect classified as an abscess secondary to trauma per (wound management consultant) NP (Nurse Practitioner) Area measures 6.5 x 5.0 x 4.0 cm. Tunneling noted. Adipose tissue is visible. Large amount of coagulated blood removed from wound. Rocephin (antibiotic) 1 gram ordered x 5 days."

Wound management consultant progress notes dated 4/11/19, documents the wound to R25's left lateral knee as 6.5 cm x 5.0 cm x 4.0 cm, with exudate having "Large Amount tea color."

R25's Face Sheet undated, documents R25 having the following diagnoses in part, "Heart failure, Chronic Obstructive Pulmonary Disease (COPD), Muscle weakness, Contusion of left lower leg, and early complications of trauma."

Minimum Data Set (MDS) dated 9/11/19, documents R25 having severely impaired cognition, and requiring total dependence for transfer with two or more physical assistance.

On 10/23/19 at 1:03 PM, V10, V12, and V14, CNAs, all assisted with a full mechanical lift transfer from R25's high back wheelchair to the bed. V14 and V12 applied the straps of R25's sling to the full mechanical lift. As V10 raised the full mechanical lift from R25's high back chair, V12 stepped away from the wheelchair, and V14 moved the high back wheelchair toward the bed, leaving R25 suspended in the air free swinging above the floor. R25's wheelchair remained unlocked prior to and during the transfer. V14, CNA, stated she was unaware of a specific policy

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or procedure on whether or not to lock the wheelchair.

On 10/24/19 at 8:36 AM, V12, CNA, stated she has been a CNA for about 8 years. She stated she is not aware of a specific procedure on the use of the full mechanical lift, only that the lift has information printed on it for how much weight it holds.

On 10/23/19 at 2:40 PM, V1, Administrator, stated R25 fell out of the full mechanical lift while being transferred.

On 10/24/19 at 9:15 AM, V2, Director of Nursing (DON), stated the abscess to R25's left lower knee was the direct cause of the fall on 3/2/19, and that R25 has a "deformity from having the abscess, and the wrong sling was used on her," and she fell causing the injury to her left leg.

On 10/28/19 at 9:14 AM, V2, DON, stated the indentation to R25's left lower extremity measures 3.1 cm (length) by 1.0 cm (width) and is 1.1 cm deep.

10/23/19 1:58 PM, V15, Medical Director (MD), stated R25's hematoma and abscess wouldn't have happened had she not fallen from the full mechanical lift. V15 further stated R25 came to the facility as a functional quadriplegic, was in poor health and improved with therapy, and is currently declining further.

2. On 10/23/19 at 10:33 AM, V17, CNA and V16, CNA, transferred R38 from her high back wheelchair to her bed using a full mechanical lift. V16 and V17 connected the sling to the lift, raised R38 up over the highback wheelchair and over to

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the bed and lowered her into her bed. The highback wheelchair was not locked prior to and during the transfer.

3. On 10/23/19 at 11:40 AM, V17 and V16, transferred R36 from her bed to her highback wheelchair using a full mechanical body lift. V17 and V16 placed the sling under R36 and connected it to the lift, and raised her up over the bed and over to the wheelchair and lowered her down into the wheelchair. Only 1 brake on the wheelchair was locked. The highback wheelchair has 4 wheels, each wheel has a lock and only 1 lock was on. The wheelchair was easily moveable with 1 brake locked.

On 10/24/19 at 9:45 AM, V2, DON, stated, "Staff should lock the wheelchair prior to transferring residents with a mechanical lift and the facility does not have a procedure to instruct staff on transferring residents with full mechanical lifts."

The Manufacturers Guidelines, Instructions for Use, dated 12/2018, documents in part, Safety Instructions, WARNING: To avoid falling during transfer, always make sure that the brakes are applied on all equipment being used.

(B)