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S 000	Initial Comments Annual Licensure and Certification	S 000		
S9999	Final Observations Statement of Licensure Violation 300.610a) 300.1210a) 300.1210b)5) 300.1210c) 300.1210d)6) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental	S9999	**Attachment A** **Statement of Licensure Violations**	

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and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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:

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.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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

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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 regulations were not met as evidence by:

Based on observation, interview, and record review the facility failed to ensure residents were transferred in a safe manner for 4 of 5 residents (R22, R17, R27 and R23) reviewed for transfers in the sample of 12.

These failures resulted in R22 sustaining two broken bones in R22's ankle.

The findings include:

1. R22's computerized face sheet showed diagnoses including dementia, muscle weakness, gait and mobility abnormalities, osteoporosis, and right foot drop. R22's facility assessment dated 10/28/19 showed severe cognitive impairment. The facility assessment showed R22 was totally dependent on staff for transfers on and off the toilet. R22's Fall Risk Assessment dated 10/14/19 showed at high risk for falls. R22's progress note dated 11/13/19 at 8:50 AM, showed R22 was found on the floor of her bathroom with her right leg in external rotation (turned outward).

On 11/19/19 at 2:32 PM, R22 was lying in bed with her right ankle wrapped in a cast, which was resting on top of a pillow. R22 stated she fell while being transferred off the toilet and onto her wheelchair. R22 said she was being transferred by only one CNA (Certified Nurse Aide). R22 said the aide helped her into a standing position while she reached for the wall grab bar. R22 said the CNA was a newer employee and had never

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transferred her before. R22 said the CNA did not put a gait belt around her waist and R22 slipped while moving off the toilet. R22 stated she was sent to the hospital because of a broken ankle.

On 11/20/19 at 1:58 PM, V8 (CNA) stated she was helping R22 go to the bathroom. V8 said she transferred R22 onto the toilet without the use of any mechanical device or assistance by other staff members. V8 said R22 did reach for the wall grab bar while V8 provided pericare, put on a clean brief, and pulled up her pants. V8 said she directed R22 to move her right foot over and pivot into the wheelchair. V8 said R22's feet got tangled up and her legs became weak. V8 said she lowered R22 to the ground by holding her under her arms and by the back of her pants. V8 said R22 did not have a gait belt on. V8 said she had forgotten to use it when transferring R22 on and off the toilet. V8 said R22 is weak on one side and the gait belt helped to stabilize her during transfers. V8 said R22 was either a sit to stand lift or two person assist for transfers. V8 said the lift was broken that day and she could not find anyone to help her, therefore she transferred R22 by herself. V8 said she yelled out for help after R22 fell to the floor.

On 11/20/19 at 2:09 PM, V6 (CNA) said she responded to R22's fall. V6 said when she entered the bathroom, R22 was on the floor and her leg was bent in a "fake and unnatural position". V6 said nurses were immediately notified. V6 said she had transferred R22 in the past and she was a sit to stand or two person assist for transfers.

On 11/20/19 at 2:59 PM, V10 (Licensed Practical Nurse) said she responded to the aides report of R22's fall. V10 said R22 was immediately sent

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out to the emergency room. V10 said she did not see any mechanical lift in the room or a gait belt around R22. V10 said, "I think she (R22) is a one assist, stand pivot transfer." V10 said R22's care plan would reflect how she transferred on and off the toilet.

On 11/21/19 at 1:44 PM, V2 (Director of Nurses) said gaits belts are used to aid in walking and transferring residents. V2 said anyone who is a fall risk needs them. Gait belts are used to hold onto residents in a safe manner.

On 11/20/19 at 3:05 PM, V1 (Administrator) stated he did a fall investigation after the incident. V1 said V8 (CNA) was the only staff member involved in the transfer and a mechanical lift device was not used. V1 also stated R22 should have been transferred as stated on her care plan. V1 said R22 suffered a broken tibia and fibula (ankle bones) due to the fall.

On 11/20/19 at 3:14 PM, V3 (MDS/Care Plan Coordinator) said R22's care plan was updated following the fall and shows she should be a sit to stand as of 11/13/19. V3 said the intervention was determined following her fall investigation as stated in the Quality Assurance Analysis binder. V3 said R22 was a one assist with a gait belt prior to her fall. V3 said R22 had standing issues and one sided weakness. V3 said gait belts are absolutely necessary for control if a resident begins to fall.

On 11/21/19 at 12:30 PM, V2 (Director of Nurses) stated resident care plans drive a resident's plan of care. V2 said staff should be looking at the care plan to determine how a resident should be transferred. R22's care plan was reviewed with V2 present. V2 stated R22's care plan did not

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show how she should have been transferred prior to the fall and the aides had no idea how she should have been transferred. V2 said she could not say if R22 should have been transferred with a sit to stand lift, a one person, or two person assist. V2 said there is nothing shown on the care plan. V2 said. "That is a huge potential for falls and injuries which is exactly what happened to (R22)." V2 said R22 was transferred wrong and fell, breaking her ankle because of it. V2 said R22 cannot bear weight now due to the broken ankle and requires a total mechanical lift. Again, R22's care plan was reviewed with V2 which showed a new intervention dated 11/13/19 (the day of the fall). The intervention showed: Use sit to stand for transfers. V2 stated, "No, the care plan is still incorrect. There is no way (R22) can be a sit to stand. That is a wrong intervention. Staff definitely should not be following the updated fall care plan."

On 11/21/19 at 10:25 AM, R22's room door signage still indicated a one person assist for transfers.

R22's local emergency room discharge summary dated 11/13/19 showed: reason for visit-leg deformity, fall. Diagnosis-broken leg. Distal right tibia and fibula with tenderness and rotation outward. Findings: The right calf has been placed in a plaster cast.

2. R17's computerized face sheet showed diagnoses including altered cognitive communication deficit, mental status, muscle weakness, gait and mobility abnormalities. R17's facility assessment dated 10/16/19 showed severe cognitive impairment. The facility assessment showed R17 requires extensive assistance from staff for all transfers.

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On 11/19/19 at 11:23 AM, V8 and V9 (Certified Nurse Aides) sat R17 up in bed and began to transfer her out of her bed and into the wheelchair. V9 applied a gait belt around R17's waist. V8 stood on one side and V9 stood on the other side of R17. Each aide grabbed the gait belt around R17' back with one arm and looped their arms under R17's arm pits. V8 and V9 then lifted R17 out of the bed and place her into the wheelchair. R17's feet were completely 6 to 8 inches off of the floor throughout the transfer.

On 11/21/19 at 12:23 PM, V2 (Director of Nurses) stated if a resident is unable to bear weight, a mechanical lift should be used. V2 said, "No, it is never appropriate to lift a resident out of bed!" V2 said it is unsafe for residents to be lifted. Residents could be dropped, joints could be dislocated and/or nerve damage could occur. V2 said, "Absolutely not! Lifting a resident is not safe!" V2 said residents should be transferred in the manner reflected in their care plans. R17's care plan was reviewed with V2 present. V2 said (R17's) care plan does not show how she should be transferred.

3. R27's computerized face sheet showed diagnoses to include history of traumatic brain injury, dementia, lack of coordination, and history of falls. R27's facility assessment dated 11/4/19 showed severe cognitive impairment. The facility assessment showed R27 requires total staff assistance from staff for all transfers.

On 11/19/19 at 12:04 PM, R27 was lying in a low bed which was only inches off the floor. V8 and V9 (CNAs) sat R27 on the edge of the bed and applied a gait belt around his waist. R27 was resistive to the transfer and V8 exited the room to

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get additional help. At 12:22 PM, V7 (CNA) entered the room to assist. V9 and V7 each grabbed the gait belt and looped their arms under R27's armpits. The aides pulled R27 up and off the low bed to place him in his wheelchair. R27 did not stand on his feet and his toes dragged across the floor during the transfer.

4. The facility face sheet for R23 shows diagnoses of dementia, hypertension and muscle weakness. The facility assessment dated 10/28/19 shows her to have moderate cognitive impairment and requires extensive assist of one for transfers.

On 11/19/2019 at 11:16 AM, V7 and V8 CNA's (Certified Nursing Assistants) were getting R23 up for lunch from her bed. R23 was in a low bed that can not have the height adjusted. V7 and V8 loosely applied the gait belt to R23's waist and the gait belt was gaping in the back. V7 and V8 reached under R23's arms and lifted her to a standing position. The weight of R23 was resting on V7 and V8's arms. R23's knees were bent and not fully holding her weight. V7 said it is difficult to get R23 out of the bed since it is so low.

On 11/21/2019 at 8:24 AM, V5 CNA said R23 is difficult to get up from the low bed. V5 said it takes two CNA's reaching under her arms to get her up to a standing position.

On 11/21/2019 at 1:38 PM, V9 CNA said a gait belt should be applied to the residents waist tight enough so only two fingers can be inserted between the gait belt and the resident.

On 11/21/2019 at 8:32 AM, V4 RN (Registered Nurse) said a resident should be lifted using a

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S9999	Continued From page 8 gait belt not under the residents arms. On 11/21/2019 at 10:00 AM, V3 RN Restorative said in order for a resident to be a 1-2 person assist pivot transfer the resident must be weight bearing, have strength and stability. V3 said a resident in a low bed that can't be raised should be a mechanical lift transfer for the safety of the resident. V3 said a resident should never be lifted under the arms because it can injure the resident. The facility policy for Transfer Belts/Gait Belts with a revision date of 4/10/2006 shows To promote safety in transferring and ambulating residents, a gait belt is utilized when deemed appropriate by nursing or therapy staff. All certified nursing assistants and licensed personnel engaged in the lifting and transferring of residents will use gait belts. Mechanical lifts will be used when the use of the gait belt does not provide an adequate margin of safety. Gait belts are mandatory. A gait belt is used if indicated on the care plan and/or kardex. Monitor the resident during transfers for: B. Decline in the amount of effort given by the resident C. Inability to participate in the transfer. (B)	S9999		