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	IL6016877	A. BUILDING: _____ B. WING _____	C 12/17/2019

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SPRINGS AT MONARCH LANDING, THE	2308 NORTH ROUTE 59 NAPERVILLE, IL 60563

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S 000	Initial Comments Complaint 197809/IL 117968	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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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.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These Regulations were not met as evidenced by:

Based on observation, interview, and record review, the facility failed to follow the facility transfer policy during a resident transfer requiring the use of a mechanical lift and two staff for assistance.

This failure resulted in the resident experiencing an acute displaced femoral shaft fracture.

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This applies to 1 resident (R1) reviewed for injuries.

The findings include:

Face sheet, dated 12/4/19, shows R1's diagnoses included displaced fractured shaft of right femur, Parkinson's disease, dementia, Alzheimer's disease, major depressive disorder, chronic kidney disease, coronary heart disease, panic disorder, urinary tract infection, and pain.

MDS (Minimum Data Set), dated 10/14/19, shows R1's cognitive status was severely impaired, and R1 required the extensive assistance of two staff for transfers, bed mobility, toileting, and personal hygiene.

ADL (Activity of Daily Living) care plan, dated 5/19/16, shows R1 had impaired mobility due to weakness and had an intervention, dated 7/23/19, that R1 was to have the extensive assistance of two staff for bed mobility/toileting and the use of a mechanical lift for transfers.

Hospital physician history and physical, dated 12/1/19, show R1 was admitted to the hospital emergency room with a diagnosis of right distal femur fracture. The record shows the facility staff noticed R1's right leg was swollen and was unsure if R1 injured herself or fell. Physician Assessment / Plan shows, "Right femur fracture, unclear etiology, likely due to unwitnessed fall, injury."

Initial facility report, dated 12/1/19, shows R1 sustained an injury of unknown origin.

Final facility report, dated 12/4/19, shows the

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facility investigated R1's injury of unknown origin and, "It was determined that the injury was sustained when the resident was lowered to the floor during a transfer. The resident's care summary states that the resident's transfer status is a two person assist with the use of a mechanical lift lift. The CNA (Certified Nursing Assistant) assigned to the resident's care performed the transfer individually without mechanical assistance. The facility concludes that the CNA's failure to follow the resident's care summary is the root cause of the injury."

Witness statement, dated 12/4/19, shows V6 (CNA) stated she was assigned to R1 on 12/1/19 during the AM shift. V6 dressed R1 and attempted to transfer R1 from the bed to the wheelchair independently. R1 began to lose her balance and slid down V6's leg. V6 lowered R1 to the floor, and V6 placed a pillow underneath the resident's head. V6 called V7 (CNA) for assistance with R1 and together they transferred R1 from the floor to her chair. V6 and V7 brought R1 out of the room at approximately 8:00 AM in her wheelchair. V6 stated she informed the nurse she lowered R1 to the ground at that time and asked if she should fill out anything regarding R1 being lowered to the ground. V8 (LPN- Licensed Practical Nurse) stated no paperwork was required because the incident was not considered a fall. The statement shows R1 first showed signs of discomfort prior to lunch when R1's foot was placed on her footrest and R1 began to scream more than usual. R1 then ate lunch and V8 applied pain relieving cream to R1's knee after lunch. At approximately 2:00 PM, V6 and V7 transferred R1 back to bed.

Witness statement, undated, shows V9 (CNA) cared for R1 on 12/1/19 during the PM shift and

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received R1 in bed sleeping. At 4:10 PM, V9 attempted to get R1 up from bed from dinner and "when V9 lifted the blanket the resident screamed and she noted that the resident's right leg near the knee was noticeably larger than the left leg."

Witness statement, undated, shows V8 (LPN) was assigned to R1 on 12/1/19 and V6 informed V8 that she lowered R1 to the foot rests of R1's wheelchair. V8 stated he applied pain relieving gel to R1's knee after lunch but did not observe swelling at that time. V8 stated he did not consider the change in R1's pain due to a fall because R1 did not land on the ground.

Witness statement, undated, shows V7 stated she assisted V6 on 12/1/19 in transferring R1 at approximately 8:00 AM from the ground to the chair and after lunch from R1's chair to the bed.

On 12/4/19 at 12:50 PM with V11 (ADON-Assistant Director of Nursing), V2 (Director of Nursing) stated R1's fall occurred during a transfer on 12/1/19 at approximately 7:30 AM during the AM shift when V6 began to transfer R1 by attempting to stand R1, with no assistance from another staff and no use of a mechanical device, and R1 was unable to bear weight on her legs and began sliding down to the floor. V2 stated V6 was trained and knew that R1 required two staff and a mechanical lift device for a safe transfer. V2 stated there was no gait belt on the resident at the time of the fall, per her investigation. V2 stated V6 told V2 during the initial transfer: that R1 started to slide lower down, R1's feet crisscrossed under V6's forward leg and V6 lowered her to the floor. V6 then called V7 (CNA) into the room and, without calling the nurse to assess R1 while on the floor, they performed a two person transfer on R1 without a

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mechanical device and placed her into the wheelchair. V6 later asked V8 (LPN) if V6 needed to fill any paperwork out because R1 slid to the floor. V8 asked if R1 fell, and V6 told V8 no, that R1 was lowered to the floor. V8 did not consider that a fall and did not instruct V6 to do a witness statement. V2 stated V8 did not clinically assess R1 at the time of the fall and did not complete an incident report. V2 stated R1 was again transferred without the use of a mechanical device after lunch when put to bed. V2 stated her expectations of the staff were that the V6, V7 and V8 should have recognized R1 fell, V6 should have reported R1's fall immediately to V8 who should have assessed R1 for injuries, V6 and V7 should not have moved R1 when she fell, and V6 and V7 should never have transferred R1 without the use of a mechanical device and two staff assisting. V2 stated Resident Summaries are located in resident closets and staff are trained on orientation to look at the resident summaries for transfer status.

On 12/16/19 at 2:45 PM, V10 (RN-Registered Nure) stated no staff endorsed R1's fall to him at change of shift on 12/1/19 when he began his PM shift.

Nursing note 12/1/19 16:37, V10 (RN) wrote, "1615 CNA informed RN of right thigh swelling and RN went to room, resident in bed and noted swelling on right thigh, no bruising, no redness noted. RN noted pain 4/10 pain to right femur when touched and moved, [pain relieving] gel applied to area of pain. RN instructed CNA not to move resident due to pain while moving. 1625 RN contacted [V13 (Physician)] STAT (Urgent) X-ray of right femur ordered, processed and noted. RN informed nursing supervisor. 1630 RN informed POA (Power of Attorney) via

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voicemail of patient status and MD (Physician) order, requested for a callback. 1635 RN contact [X-Ray] 1645 [X-ray] technician did X-ray of right thigh....1815 [X-ray] faxed to unit right femur X-ray results and informed [V13] of right femur fracture, telephone ordered to send resident to ER ...."

On 12/16/19 at 1:50 PM V13 (Physician) stated it was his expectation that the staff would notify the nurse at the time R1 was lowered to the ground for the nurse to assess R1 prior to staff moving R1. On 12/16/19 at 1:50 PM, V13 (Physician) stated R1 being improperly transferred and subsequently lowered to the ground could have "quite possibly" caused the femur fracture.

Hospital physician history and physical, dated 12/1/19, show R1 was admitted to the hospital emergency room with a diagnosis of right distal femur fracture. The record shows the facility staff noticed R1's right leg was swollen and were unsure if R1 injured herself or fell. Physician Assessment / Plan shows, "Right femur fracture, unclear etiology, likely due to unwitnessed fall, injury."

Initial facility report, dated 12/1/19, shows R1 sustained an injury of unknown origin

Resident Summary, dated 12/5/19 shows R1 required a mechanical lift with the assistance of two staff for bed to chair and chair to bed transfers.

Resident Summary and Fall inservice document, 12/2/17, shows "Resident Summary - this is the sheet that is posted behind the door of every resident's closet and also in the kiosk that has the information on how to take care of a patient or

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resident, which includes diet, transfer any special care. The resident Summary must be read each shift. The Resident Summary must be followed and when in doubt, clarify with the nurse. Fall - Unintentionally coming to rest on the ground, floor, or other lower level. An episode where a resident lost his/her balance and would have fallen, if not for another person or if he or she had not caught him/herself, is considered a fall. A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred. If these occur, need to be reported to the nurse before assisting the resident back to the bed or chair. The nurse then will assess the patient, document and inform POA (Power of Attorney) and family"

Facility document Assessing Falls and Their Causes, revised March 2018, shows, "Steps in the Procedure After a Fall: 1. If a resident has just fallen, or is found on the floor without a witness to the event, evaluate for possible injuries to the head, neck, spine, and extremities. 2. Obtain and record vital signs as soon as it is safe to do so. 3. If there is evidence of injury, provide appropriate first aid and/or obtain medical treatment immediately. 4. If an assessment rules out significant injury, help the resident to a comfortable sitting, lying or standing position, and then document relevant details. 5. Notify the resident's attending physician and family in an appropriate time frame. a. When a fall results in a significant injury or condition change, notify the practitioner immediately by phone. B. When a fall does not result in significant injury or condition change, notify the practitioner routinely (e.g., by fax or by phone the next office day). 6. Observe for delayed complications of a fall for approximately forty-eight (48) hours after an

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S9999	Continued From page 8 observed or suspected fall, and will document findings in the medical record. 7. Document any observed signs or symptoms of pain, swelling, bruising, deformity, and/or decreased mobility; and any changes in level of responsiveness/consciousness and overall function. Note the presence or absence of significant findings. 8. Complete an incident report for resident falls no later than 24 hours after the fall occurs. The incident report form should be completed by the nurse on duty at the time. After an observed or probable fall, clarify the details of the fall, such as when the fall occurred and what the individual was trying to do at the time the fall occurred." (A)	S9999		