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
	IL6016869	A. BUILDING: ______ B. WING ______	C 11/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN COURTS OF SHOREWOOD	700 WEST BLACK ROAD SHOREWOOD, IL 60404

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S 000	Initial Comments Complaint Investigation Surveys # 2074565/IL123794 # 2077385/IL126903	S 000		
S9999	Final Observations Statement of Licensure Findings: 300.610a) 300.1210b) 300.1210c) 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. 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	S9999	Attachment A Statement of Licensure Violations	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.
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 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.

This REQUIREMENT is not met as evidenced by:

Based on interview and record review, the facility failed to provide safe transfer to a resident requiring extensive assistance from two staff.

This applies to 1 of 3 residents (R2) reviewed for fall in the sample of 5.

This failure resulted in R2 sustaining acute fracture to the upper end of the right and left tibia after a fall during a one staff manual transfer.

The findings include:

R2 has multiple diagnoses which included dementia without behavioral disturbance, adult

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failure to thrive, generalized muscle weakness, cerebrovascular disease and cerebral infarction, based on the medical diagnosis sheet.

R2's fall risk assessment dated 7/19/20 and 9/12/20 (post fall) shows that the resident is at risk for fall.

R2's quarterly MDS (minimum data set) dated 7/20/20 shows that the resident is severely impaired with cognition. The same MDS shows that R2 would require extensive assistance from two staff during bed mobility and transfer.

R2's incident report dated 9/12/20 (6:15 AM) shows, "Nurse informed that resident was on the floor in her room. Writer entered room and observed resident lying on the floor by her wheelchair next to her bed with head on a pillow. Per CNA (Certified Nursing Assistant), she attempted to transfer resident from bed to wheelchair when her knees gave out and she was slowly lowered to the floor and did not bump her head. Resident unable to give description." The incident report documented under level of pain shows, "Repeated troubled calling out. Loud moaning or groaning. Crying; Facial Grimacing; Rigid, Fist Clenched, Knees pulled up, Pulling or Pushing away. Striking Out; Unable to Console, Distract or Reassure." The incident report has a witness statement which shows in-part, "I moved her to the edge of the bed and arranged the bed to be the same height as w/c (wheelchair) and applied the gait belt. She is normally able to bear weight for a moment during pivot transfer. When I stood her up, the gait belt slipped underneath her shirt. I didn't want to pinch her skin, so I did not use the gait belt during the transfer. I attempted to use her pants to stabilize her, but I felt the brief tear and both her knees gave out. I

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was unable to transfer her, so I held her and slowly lowered her to the floor. Her bottom touched the floor and she did not bump her head. Before leaving the room to get the nurse, I placed a pillow under her head." The same incident report under the notes section shows in-part, "Nurse was informed that resident had a witnessed fall." "Bilateral knees observed to be swollen with abrasion to right knee without active bleeding. Resident was transferred via extensive assist of two staff and gait belt into w/c and brought to nurse's station for close monitoring. Resident c/o (complained of) pain to ble (both lower extremities), and prn (as needed) Dilaudid was administered per (physician) orders." "X-rays completed in house confirmed proximal tibial shaft fracture of left and right tibia without displacement." The incident report shows that R2 was sent to the hospital for evaluation and treatment.
The facility's final report to the State Agency dated 9/17/20 shows in-part, "On September 12, 2020 resident was being pivot transferred with gait belt from bed to wheelchair via assist of one staff. (R2) was weak during the transfer and staff lowered her to the floor."

R2's left tibia/fibula x-ray result dated 9/12/20 (completed at the facility) shows, "Acute proximal left tibial fracture without displacement." R2's right tibia/fibula x-ray result dated 9/12/20 (completed at the facility) shows, "Proximal tibial shaft fracture, similar to left tibia."

R2's ADL (activities of daily living) self-care performance deficit care plan effective 7/20/2020 through 9/14/2020 shows multiple interventions which included, "Assist with transfers as needed. (R2) requires two-person assistance with transfers."

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R2's skin integrity care plan initiated on 8/1/2017 with a target date of 10/18/2020 shows multiple interventions which included, "(R2) will require the use of two people assistance during transfer due to skin being fragile and limited assistance from (R2) during transfers."

On 10/29/20 at 11:00 AM, V2 (Director of Nursing) was asked how the nursing staff would know how much assistance is needed to transfer a resident. V2 stated that each resident has a posting on a board on top of the bed to indicate how much assistance each resident need during transfer. The board on top of R2's bed had a posting of letter "T." According to V2, "T" meant total assistance with transfers. V2 stated that the "T" posting was placed after R2 returned from the hospital on 9/14/20, post fall (9/12/20). V2 stated that when R2 had a fall on 9/12/20, there should be a posting on the board above R2's bed of number "2." According to V2, "2" meant two staff assistance during transfers.

On 11/4/20 at 10:32 AM, V4 (CNA) stated that on 9/12/20 during the first hour of her shift (started at 6:00 AM), she attempted to assist R2 from bed to the wheelchair without any other staff assistance because the resident normally is able to bear weight during a pivot transfer. According to V4, she took care of R2 before and there are times that the staff (including her (V4)) would transfer R2 with or without assistance from another staff. V4 stated that after she assisted R2 with dressing on the morning 9/12/20, she (V4) applied a gait belt around R2's waist to assist with transfer. V4 stated that when she assisted R2 to stand up, the gait belt started to slip underneath R2's shirt because the resident's shirt was short. To avoid pinching R2's skin, she (V4) moved to the right

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S9999	Continued From page 5 side of R2 (while still holding on to the gait belt), grabbed the back of R2's pants (back of the waist) with her (V4) left hand to assist with transfer, while using her right hand to hold on to R2's right arm. According to V4 she did not use the gait belt to transfer R2. V4 stated that it was during the middle of the transfer, while holding on to R2's pants (back of the waist) and right arm, that R2's knees gave out (bent forward) and the resident's body started leaning forward. According to V4, it was during this time that she lowered R2 to sit on the floor, then eventually laid the resident on the floor and placed a pillow under the resident's head before calling the nurse. V4 claimed that R2 did not hit her head, her knees, her legs or any part of her body during the attempted transfer. V4 was asked how the nursing staff would know how much assistance is needed to transfer R2. V4 responded, "normally there is a posting on the board on top of the resident's bed, but I do not remember if there was one on R2's board." On 11/6/20 at 10:55 AM, V8 (nurse) stated that on 9/12/20 at around 6:15 AM, she was called by V4 to inform her that R2 was on the floor. V8 immediately went to R2's room, saw the resident lying on the floor with a pillow behind her head and R2's wheelchair was by her side. V8 stated that according to V4, she was attempting to transfer R2 from the bed to the wheelchair by herself, but for some reason, R2 was not able to help with the transfer and she (V4) had to lower R2 to the floor, placed a pillow behind the resident's head and call for the nurse (V8). V8 stated that she assessed R2 from head to toe and noted an abrasion on the resident's right knee and a small lump/swelling on both knees. According to V8 during her assessment of R2, the resident did not complain of pain however, R2	S9999		

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was very anxious, nervous, with facial grimacing, and occasional moaning and groaning. V8 stated that R2 was able to move her upper extremities without pain or limitation and when her lower extremities are being moved, she would start to moan, groan and show facial grimacing. According to V8, she gave R2 a pain medication which calmed the resident. However, after about 30 minutes she noticed that the swelling on R2's bilateral knees increased in size. V8 stated that since the incident was close to the change of shift, the morning shift nurse contacted the physician and obtained the order for the x-ray.

On 11/4/20 at 10:39 AM, V5 (Physician) stated that with regards to R2's transfer assistance (such as how many and what device should be used during the transfer), he would like the facility to refer to R2's plan of care to ensure proper and safe transfer.

The facility's policy and procedure regarding gait belt/transfer belt dated 9/2020 shows that, "To assist with a transfer or ambulation. A gait belt will be used with weight-bearing residents who require hands on assistance."

(A)