STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014872	A. BUILDING: _____ B. WING _____	C 12/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY REHAB & HCC	3298 RESOURCE PARKWAY DEKALB, IL 60115

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S 000	Initial Comments Facility Reported Incident of 12-3-19/IL118275	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 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 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. d) Pursuant to subsection (a), general nursing	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1	S9999		

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.

These requirements were not met as evidenced by:

Based on interview and record review the facility failed to ensure a resident had non skid foot wear and a gait belt applied prior to transfer. These failures resulted in R1 slipping during a transfer and sustaining a fractured left arm. This applies to one of three residents (R1) reviewed for falls.

The findings include:

On 12/11/19 at 8:45 AM, R1 said V6 Certified Nursing Assistant (CNA) removed her shoes and attempted to transfer her from the recliner to the bed. R1 stated, "V6 was holding my left arm and pants. My right foot slipped and V6 landed in the chair under and behind me. My left arm went over my head and hurt immediately. V6 called for help and another girl came to help. They discussed how to get me up and one CNA grabbed my legs and the other grabbed my upper body and they carried me to my bed. I had regular socks on, not the ones with skids." R1 further stated, The nurse didn't look at me until much later and it was days before they did anything. I thought they should have sent me out sooner. The worst part was being in pain for days. I complained of pain in the arm and they said they couldn't give me anything

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S9999	Continued From page 2	S9999		

but Tylenol. I think they thought it was in my head. It made me feel better when I went to the hospital and found out it was fractured. I knew I wasn't overreacting. The fact that my shoes were off contributed to the fall. I had a stroke about a year ago and my left arm and leg are paralyzed." At 12:05 PM, V6 said she did attempt to transfer R1 without a gait belt and with her shoes off. V6 stated, "R1 slipped and I held her and yelled for help. V7 (CNA) came in and we lowered R1 to the floor. Then we both lifted R1 from the floor and put her in bed. We told the nurse what happened right away. It was a new nurse who had only been there a couple weeks. This happened on Thanksgiving Day (11/28/19) after 6:00 PM." At 12:15 PM, V7 stated, "V6 called for help from R1's room. I ran in to help and slipped in urine on the floor. R1's catheter was leaking. We couldn't get R1 into the chair so we lowered her to the floor. Then, me and V6 lifted R1 into her bed. I carried her legs. We (V6 and V7) told V4 (Licensed Practical Nurse) about the incident. This incident happened 11/28/19."

At 1:00 PM, V5 (R1's son) said he heard about the incident from his mother a day or two after it happened. V5 stated, "I visited the weekend after Thanksgiving. R1 told me she slipped during a transfer and her left arm was extended upward. Mom said her arm was sore. The facility didn't call me until they wanted to do an x-ray." At 9:55 AM, V1 (Administrator) stated, "There is no facility policy on transferring a resident. We do skills checks." V2 (Director of Nursing/DON) stated, "I didn't know the incident occurred on Thanksgiving or that R1 was lifted to the bed by V6 and V7. I didn't know R1 was lowered to the floor. It is not safe or appropriate to transfer a resident paralyzed on one side without a gait belt. The lack of using the gait belt contributed to R1's

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S9999	Continued From page 3	S9999		

fractured arm." V3 (R1's physician and facility Medical Director) stated, "The improper transfer definitely caused R1's broken arm." V3 said he was not aware R1 was carried to her bed after the incident or that the incident occurred on 11/28/19. V3 said R1 would have been treated sooner if he was notified about it at the time of the occurrence.

The facility's staff schedule for 11/28/19 showed V4, V6 and V7 worked the 3P-11P shift. The facility's investigative report dated 12/3/19 showed a written statement from V6 stating V6 transferred R1on Thanksgiving Day without shoes on. This statement showed R1 began to fall and V6 held her up under the arms and grabbing R1's pants. V6 admits in the written statement that a gait belt was not used and R1 said "Oh my arm." V6's statement showed V6 notified the nurse. V7's written statement showed R1 lost her footing and believes R1 slipped on urine as R1's catheter was leaking. V7's statement showed V6 and V7 lowered R1 to the floor and then lifted her into bed. This statement showed V7 notified the nurse (V4).

R1's care plan showed additional fall interventions were not implemented until 12/4/19. R1's face sheet dated 12/11/19 showed a diagnosis of hemiplegia (paralysis on one side of the body) on the left side following a stroke and unsteadiness on her feet. R1's Fall Risk Data Collection dated 11/7/19 showed a low risk for fall. There was not an updated Fall Risk form in R1's electronic record since 11/7/19. An Occurrence Report for the 11/28/19 incident was not done until 12/3/19. This report showed the fall happened on 11/28/19. R1's Occupational Therapy note dated 11/8/19 showed R1 was seen for left upper extremity x-ray at hospital on

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S9999	Continued From page 4	S9999		

12/4/19 due to continued pain since incident occurring with nursing staff during transfer where patient had to be lowered to the floor. R1's CAT scan result dated 12/5/19 showed a displaced fracture involving the left humerus. V4's late progress note dated 11/28/19 showed V4 was aware of a transferring incident. R1's progress note dated 12/2/19 showed R1 reported increased left shoulder pain as a result of a transfer that did not go as smoothly and caused slight traction on the left upper extremity. This note showed a decrease in left shoulder shrug.

V6's personnel file showed on 11-17-19 V6 was reeducated on gait belt use for all transfers and ambulation following a resident fall and on 9/13/19 corrective action was given for failure to follow safety rules.

A facility policy for gait belt use was requested and none was received.

The facility's Fall Prevention Policy dated February 2014 showed following any falls, the facility staff completes an Occurrence Report. Details of the fall will be reported and potential causative factors identified and investigated. Interventions will be immediately implemented following each fall and added to the resident's plan of care. The staff will review the resident's Fall Risk Data Collection. An update or change to the data collection form would be made only if the resident had previously been identified as low risk. All Occurrence Reports are reviewed at the daily QA (Quality Assurance) meeting to ensure that an intervention was immediately implemented, added to the plan of care and that the current intervention is appropriate. The facility's undated Significant Change & Notification Policy showed the policy's purpose

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S9999	Continued From page 5 was to ensure that the resident's family and/or representative and medical practitioner are notified of resident changes such as those listed below: An accident or incident, with or without injury, that has the potential for needed medical practitioner intervention; abnormal, unusual or new complaints of pain. When any of the above situations exist, the licensed nurse will contact the resident's representative and their medical practitioner. (B)	S9999		