STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010037	A. BUILDING: _____ B. WING _____	C 12/22/2020

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S 000	Initial Comments Facility Reported Investigation of 12/4/2020 IL 129317 - 300.610 a), 300.1010 h, & 300.1210 b)5)c)d)6	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610 a) 300.1010 h) 300.1210 b)5) 300.1210 c) 300.1210 d)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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident,	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 injury or change in condition at the time of notification. 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. 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 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. This requirement was not met as evidenced by: Based on Observation, Interview, and Record Review the facility failed to provide a safe transfer for a resident which resulted in a fracture on	S9999		

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S9999	Continued From page 2 12/4/2020 for 1 of 3 residents (R1) reviewed for safety in the sample of seven. The facility also failed to ensure the physician/nurse practitioner was notified of a change in condition for 1 of 3 residents (R1) reviewed for change in condition in a sample of 3. The findings include: The Incident Report dated 12/4/2020 for R1 showed, "R1 requires 1 assist with the stand lift device for transfers and activities of daily living. R1 is alert and oriented to person, time, and place and makes his own needs known. At 4:00 PM, R1 notified the RN (Registered Nurse) and stated, "I have some pain in my right ankle. At around 12:00 PM today I got a little twisted when being transferred." Upon assessment the nurse noted a swollen right ankle and mild tenderness. On 12/8/2020, R1 spoke with the nurse at 2:50 PM and stated, "My foot isn't feeling any better." The nurse contacted the physician and a STAT (immediate) X-ray was ordered at 2:58 PM. At 9:26 PM the X-ray results were received noting a "distal right fibula fracture." POAH (Power of Attorney for Healthcare) was notified at 9:40 PM and physician notified at 9:30 PM. Orders were given for non-weight bearing and plan to send to the orthopedic immediate care on 12/9/2020. On 12/9/2020 at 9:45 AM, the orthopedic immediate care informed the facility of "unable to take the resident at this time." A plan was made for the resident to be taken non-urgently to the local hospital." R1's Minimum Data Set dated 5/20/2020 showed he is cognitively intact; requires extensive assistance of two people for bed mobility and transfers.	S9999		

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R1's Care Plan dated 9/10/2020 showed, "R1 has decreased independence with mobility due to right femur fracture status post right hip arthroplasty; one assist with stand lift with all transfers and wheelchair for transport."

On 12/11/2020 at 9:24 AM - V2 DON (Director of Nursing) stated, "I don't know if the CNA didn't know the issue at the time of R1's transfer. Ask R1 and V3 CNA; I did not ask V3. An X-ray wasn't done initially; 72-hour monitoring was started; compresses, Tylenol and follow up if necessary. R1 talked to V5 NP on 12/8/2020 and he told her it was not getting better, asked if we should do something more. R1 asked V5 if we should do an X-ray and she said she could order an X-ray. I didn't know about this until Tuesday, 12/8/2020. They notify me if a resident is sent out to the hospital or has a fracture; that's why I wasn't notified on 12/4/2020. I talked to R1 and he said it happened when he was getting up. R1 said something happened and his feet got tangled. I have not talked to V3 CNA yet. R1 uses a full mechanical lift now."

On 12/11/2020 at 9:51 AM, R1 was observed sitting in a recliner in his room with an orthopedic boot on his right lower extremity. R1 stated, "I was in my wheelchair and a lady (V3 CNA - Certified Nursing Assistant) helped me out of my chair. She said to give me a hug and I will get you up. I put my arms around her neck, and she turned and raised me up to sit down here (recliner). She didn't raise me up high enough and my right foot caught in her foot on the floor. My right foot was behind one of hers and there was no room for my foot to move; it got twisted. So, the result was a broken ankle. I don't think she used a belt (gait belt). The other CNA's do the same procedure. Ideally, she was to raise me

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up, so my feet cleared; she didn't have me stand up all of the way. I thought I heard a sound and I may have made a comment that my ankle was broken. I know V3 CNA was concerned. I notified the nurse later that it happened. Days later I was going to lunch on my own, pedaling myself (in a wheelchair) using my heel to propel me forward and I saw V5 NP (Nurse Practitioner) at the nurse's station. I told her I thought my ankle was broken and maybe I should have an x-ray of my ankle; she said we will get right on that immediately. I was then notified later by the nurse that the X-ray showed my ankle was broken. They decided to wait until the next day for me to be seen. I thought I would get into the orthopedics doctor right away; apparently it doesn't work that way. They decided to send me to the ER (Emergency Room). I am not sure I had a choice. I needed to get my ankle looked at as quickly as possible." R1 was asked if he would have liked to have his ankle looked at sooner and he replied, "Ideally yes; there wasn't a choice. I didn't see anyone until I went to the ER. The ER took my vital signs, gave me Tylenol, and sent me to the waiting room to wait. I waited a long time for a room. When I went to a room the doctor came in and I had x-rays done. Shortly after the doctor told me the type of break, fracture I had and recommended a boot which is what I have on."

On 12/11/2020 at 10:19 AM, V3 CNA stated, "R1 was in his wheelchair and wanted to go to the recliner. I positioned R1's wheelchair at an angle to his chair. I put a gait belt on R1. I counted to three for him to stand up. R1 hung onto my waist and I turned him. R1's leg must have got caught on my foot." V3 stated she only uses the stand lift device for R1 when she is taking him to the commode or for long distances.

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S9999	Continued From page 5 On 12/11/2020 at 10:40 AM, V5 (Nurse Practitioner) stated, "On Tuesday when I was on the unit, R1 was propelling himself in his wheelchair going to lunch. R1 stopped and said, "Do you remember my foot got caught in a transfer? It still hurts." R1 asked about an X-ray and I said okay. The nurse notified me R1 had a fracture of the fibula. I made R1 non-weight bearing for the night and asked them to get an appointment for the orthopedic immediate care so he wouldn't have to go to the emergency room and then get quarantined. The orthopedic immediate care said they couldn't see him without prior authorization, so we sent R1 to the emergency room. I assume they verified the fracture of the fibula. I don't remember if they called initially or how we were notified. They (facility nurse) must have gotten orders. R1 would have an order already for Tylenol." V5 reviewed R1's Medical Record and stated, "The nurse did Tylenol based off standing orders. I don't see anything in here (R1's medical record) that I signed. It might have been the on call. They should have orders in the chart if the on call gave them. It happened on a Friday so they would have had to call the on-call person or me on Monday." V5 stated nurses should call with a change in condition and no improvement in condition. V5 agreed if R1 was continuing to have soreness to his leg and wasn't getting better she should have been notified. V5 stated she should been notified so orders could be placed, an X-ray done and a boot placed to help R1 with mobility and comfort. On 12/11/2020 at 12:29 PM, V2 stated the purpose of doing 72-hour monitoring is to review signs and symptoms and to identify a change in condition. V2 stated a change in condition would be if a resident complains of increased pain, a	S9999		

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change in vital signs and a change in a body parts appearance after the first assessment. V2 stated if there is a change in condition, they should contact the nurse practitioner or medical group if she isn't at the facility and it is after hours. V2 DON stated residents are to be transferred according to their care plan and what they are assessed for.

The facility's Incident Documentation policy (no date) showed, "The time period post incident is a time that internal injuries or new symptoms can occur. Early identification can facilitate early interventions that can prevent further complications. The nursing staff post incident will fill out forms per policy, notification of physician, family and others as needed. The Nursing staff will then on all unwitnessed and witnessed incidents initiate a 72-hour monitoring process. Any changes in the assessment need to be reported to the physician, family and nursing administration."

The facility's policy on Stand Pivot Transfer (1/20/2020) showed, "Check the status of resident transfer and ambulation using the resident Kardex or Plan of Care; Position the gait belt: position belt around the waist. Move the person's bottom to the front of the surface they are sitting on so that the feet are in firm contact with the floor; To complete the transfer, the person should lean forward over their feet, use their hands to push from the surface they are sitting on, swing their bottom around to the adjacent surface and slowly sit back down."

The facility's policy for Sit to Stand Mechanical Lift transfers (8/10/2018) showed, "Necessity of sit to stand lift for transfers will be documented on resident Care Plan and Kardex."

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On 12/11/2020 at 1:54 PM, V7 RN stated, "I didn't watch it happen. I went into R1's room after 4:00 PM, at around 5:00 PM and he said his foot got twisted or tangled when he was transferred. R1 had pain but not severe pain. I assessed R1's ankle and there was tenderness and swelling to the ankle. R1's ankle hurt when I touched it. I did not see if R1 could bear weight." I faxed V5 NP, and nobody responded so I passed it on to the next nurse. I told V4 RN that R1's ankle was swollen, and that ice brought comfort. It didn't seem that bad. I did not follow up after that regarding orders and the fax to the medical group."

On 12/11/2020 at 2:05 PM, V4 RN stated, "The previous nurse told me she faxed the medical group (for R1's ankle). V7 did not tell me she didn't get a response from the medical group. If I had known I would have called the on call for the medical group just so they were aware of the incident for R1 that happened in case they wanted to order something."

On 12/11/2020 at 2:15 PM, V2 stated the fax dated 12/4/2020 notifying the NP of R1's ankle should be in his chart and that it wasn't in R1's chart. V2 stated that is where the faxes are supposed to go.

R1's medical record including his physician's orders for December 2020 was reviewed on 12/11/2020 and did not show any fax to his physician/nurse practitioner notifying them of the incident with his right ankle on 12/4/2020 or any orders received on 12/4/2020. R1's Physician Orders showed on 12/8/2020 a three view X-ray was ordered of this right ankle due to pain.

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R1's Nurse's Notes showed, "12/4/2020 - R1 informs me of some pain on ankle. "My foot got twisted or tangled when I was being transferred. It happened around noon." Upon assessment, the ankle is found to be swollen and tender; 12/5/2020 - R1 continues to be on 72-hour monitoring due to a swollen right ankle. The ankle is swollen and pink in color. R1 complained of right ankle pain and was medicated with Tylenol at 2:40 PM and 8:40 PM with good results; 12/6/2020 at 5:47 AM - 72-hour monitoring related to right ankle being swollen. Tylenol given at 5:30 AM for soreness. Mild swelling noted; 12/6/2020 at 9:12 PM - R1 remains on 72-hour monitoring due to swollen right ankle. Noted light bluish colored bruising on outer foot and underside of foot .... R1 states the pain is primarily on top of the foot. Medicated with Tylenol 650 mg at 7:00 PM with good results; 12/7/2020 at 5:59 AM - 72-hour monitoring continued for swollen right ankle. Ankle is bruised on the outer aspect of foot and the top arch of his foot. R1 was given Tylenol for mild to moderate pain; 12/8/2020 at 2:58 PM - order received for an X-ray to the right ankle due to resident still complains of pain to the area; 12/8/2020 at 9:26 PM - X-ray results received, distal right fibula fracture."

R1's Physician Orders showed on 12/8/2020 a three view X-ray was ordered of this right ankle due to pain. The X-ray report dated 12/8/2020 at 7:28 PM for R1 showed, "Acute fracture involving the right distal fibula with mild displacement." R1's X-ray did not show any disease of the bone including Osteoporosis..

The hospital AVS (After Visit Summary) dated 12/9/2020 for R1 showed he went to the emergency room for ankle pain, had X-rays done

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S9999	Continued From page 9 of his right ankle and was diagnosed with a closed fracture of the right ankle. The patient education portion of R1's AVS showed the cause of an ankle fracture may be by twisting of the ankle. It also may be caused by a fall, a direct hit to the leg, or a medical condition that causes weak or brittle bones. R1's AVS showed symptoms of a fracture may include: a snapping or popping sound at the time of injury; pain, swelling, bruising, or tenderness that happens right after the injury; and pain when the injured area is touched or that keeps you from putting weight on your foot. B	S9999		