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	IL6005300	A. BUILDING _____ B. WING _____	C 07/10/2019

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S 000	Initial Comments Complaint #1944655/IL113426	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. 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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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 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 requirements were not met evidencded by:

Based on interviews, and record review, the facility failed to prevent an avoidable incident from occurring, failed to provide adequate supervision and appropriate use of a mechanical lift to ensure safety for 3 of 3 residents (R3, R4 and R5) reviewed for falls/incidents in a sample of 5. This failure resulted in a fall from a mechanical lift, with an avulsion to the leg requiring medical evaluation/treatment for R3.

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Findings include:

1. Electronic Health Record (EHR) Progress notes dated 6/1/19 entered by V3 Licensed Practical Nurse (LPN) document R3's orders on admission from the hospital included special instructions for a full body mechanical lift.

A Physical Therapy Daily Treatment Note dated 6/19/19 written by V7 Physical Therapy Assistant (PTA) documents "PT (patient) performed sit to stands" with minimum to maximum assist and was "sometimes unable to complete sit to stands. Writer encouraged pt. bringing her feet back among other suggestions throughout session, however pt. unwilling to listen or attempt suggestions. Pt requested to be changed to a sit to stand machine from a (full body mechanical lift) and request writer put her back to bed with sit to stand machine. Writer agreed to assess safety. Pt safe with sit to stand, plan on changing pts transfer status to sit to stand machine."

The Occupational Therapy (OT) Daily Treatment Note dated 6/19/19 entered by V8, Certified Occupational Therapy Assistant (COTA) also documents R3 "demonstrates good safety on the sit to stand with machine. Provided education for staff on proper positioning of the patient in the power chair during the sit to stand lift transfer."

Progress notes dated 6/20/19 at 6:15pm entered by V6, LPN documents "CNA (certified Nurse aide) V4 and V5 - here with instructor (V9), came from the room and states that resident was being transferred per the sit to stand and her knees buckled during the transfer. Resident started to shift her body to the right and her feet went out from underneath her. She was holding on to the

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handles of the sit to stand when this happened. V4 was also behind her and was holding on to her. V4 then positioned herself underneath the resident. They lowered the rails of the sit to stand to be able to remove the sling off the sit to stand. They then 2 person assisted her to the bed. They noticed a laceration on her left lower leg that was bleeding." The note documented the physician was notified and orders were received to send R3 to the emergency department (ED) for evaluation of the laceration of the leg. The progress notes also document R3 sustained a bruise right upper and lower arm in the incident.

ED notes dated 6/20/19 documents "8cm L-shaped wound to the anterior lateral left lower leg which is predominately a skin avulsion to the superior portion and a skin tear to the inferior." The ED note also documents R3 to have bruising to the right upper arm which she reports as minimally tender. Treatment orders were given for wound care with the steri-strips to remain until they fell off.

The Drugs.com Medical Dictionary describes an avulsion wound as a "wound that happens when skin is torn from your body during an accident or other injury. The torn skin may be lost or too damaged to be repaired; A wound of this type cannot be stitched closed because there is tissue missing." The Sharecare.com site describes it as "a serious soft-tissue injury often damages deeper tissue, causing significant bleeding."

A facility Skin and Wound Evaluation dated 6/20/19 at 11:15pm documents R3's right lower leg wound as measuring 11.5cm x 4.1 cm x 3.5cm "with non-attached edges: edges appeared as a cliff."

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A Skin tear or Bruise Investigation completed by the facility dated 6/21/19 documents R3's predisposing physiological factors include "gait imbalance" but fails to identify the root cause of R3's fall during a transfer and put forth recommendations so the incident did not occur again.

On 7/3/19 at 8:45am, V1 Administrator stated R3 was being transferred by a facility employed CNA and a CNA here for recertification when the incident occurred. V1 stated they didn't identify it as a fall but as a laceration/skin tear and didn't report it because although R3 went to the emergency department, only steri-strips were applied. V1 confirmed the CNA instructor was standing in the hallway with the door closed. To her understanding when the incident occurred and didn't hear anything going on at the time.

The manufacturers booklet entitled "Stand Up Patient Lift" documents under "Using the sling" for stand assist slings, "the belt MUST be snug, but comfortable on the patient, otherwise the patient can slide out of the sling during transfer, possibly causing injury." It documents "Transfer Slings" - "Before lifting the patient, make sure the bottom edge of the transfer sling is at the base of the spine and the patient's arms are outside the transfer sling." The booklet documents under "lifting the patient" - "before lifting a patient from a stationary object (wheelchair, commode or bed), slightly raise the patient off the stationary object and check that all sling attachments are secure. If any attachment is not correct, lower the patient and correct the problem, then raise the patient and check again." Under Warnings in the booklet, it documents again "Before lifting the patient, make sure the bottom edge of the transfer sling is at the base of the spine and the

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patient's arms are outside the sling." The booklet documents staff are to ensure the patient's knees are secure against the knee pad and the feet are properly positioned on the foot plate instructing the patient to lean back into the standing or transfer sling.

The facility's policy/procedure entitled "Mechanical Lift Transfers" dated 7/8/16 documents under Sit to Stands, "Apply harness around the resident's waist and secure. Assure the resident arms are on the outside of the harness with the front strap at or just below the sternum."

On 7/5/19 at 1:10pm, V9 CNA Instructor stated he had a student, V5, who was with a facility employed CNA in R3's room doing the transfer with a sit to stand mechanical lift while he was standing outside the door. V9 stated R3 was anxious because she had been asking to go to bed for quite some time and the CNA's were still in the dining room assisting others with their meals at the time. V9 stated he heard the "fall" but "it wasn't like a big boom or anything" and when he opened the door, R3 was already on the bed and there was blood all over. V9 stated he went and got the nurse, V6 LPN to came to assess R3's leg. V9 estimated the wound as about a 4-inch skin tear on her left lower leg. When asked about whether the sling was applied appropriately to R3 prior to the fall, V9 stated yes, as he was looking through a crack in the door. When asked how this incident could happen if the sling was properly applied and her feet positioned accordingly, V9 stated he thought "her foot must have slipped off the platform during the transfer." V9 stated he thought they should have used a full body mechanical lift at the time because he didn't think R3 was ready for the sit to stand lift transfer

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but was informed by V6, LPN, that R3 had been released by Physical Therapy to use it so that's what the CNA's did. V9 stated after telling the nurse, V6, what happened, he started to clean up all the blood the CNA's had tracked through.

On 7/5/19 at 2:09pm, V6 recalled the evening of R3's fall and stated she never had a conversation with V9 regarding using a full body mechanical lift instead of the sit to stand and that R9 stood in the hallway with the door closed during the time the CNA's were transferring R3. V6 stated R3 had been cleared the day before to use the sit to stand and the sign behind her door had been changed to reflect that earlier in the day. V6 stated R3 was upset at the time of the transfer because she was wanting to go to bed and the CNA's were still in the dining room assisting with meals.

On 7/5/19 at 2:35pm, V1 Administrator stated that during transfer, R3 shifted to the side but the sling did not come off her nor did she slide out of it.

On 7/5/19 at 10:57am, R3 stated the sling was not snug when the two CNA's applied it and that the non-certified nurse aide was "running the controls." R3 stated she told the aides she was starting to slide and fall but the non-certified aide continued to lift her up despite her repeatedly asking them to go get help. R3 stated she thinks her foot fell off the side of the lift and she slid sideways adding that the aides then "just pushed" her onto the bed after that. R3 stated she didn't realize her leg had been injured until she was on the bed and saw all the blood. R3 stated her shoulder is still sore and her leg wound is still not healed. R3 stated she had just seen the physician that morning and he told her if her leg isn't healed by the next visit, he will have to send her to a

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Wound Clinic. R3 stated she hurt to where she couldn't go to her therapy for "probably a week after."

On 7/5/19 at 2:45pm, V7 PTA stated R3 had been doing the sit to stand transfers for a week or so and doing them quite safely when he and the COTA both determined she was ready to use it with the CNA's in her room. V7 stated the transfer is improper is when the arms are outside the sling, the feet are not planted correctly positioned on the platform or the sling is not applied appropriately with the bottom edge almost down to their hips. V7 stated he discussed the incident with R3 numerous times and that she repeatedly refused therapy and to get out of bed due to the soreness for at least a week following the incident. V7 stated his best guess on how it happened was that the sling was either positioned too high or not low enough to support the torso when lifting. V7 also stated the sling must be cinched snug after applied before lifting and is also too high if it is positioned over the breasts. V7 stated he would consider this an avoidable incident since R3 had been cleared to safely use the sit to stand for transfers.

On 7/10/19 at 1:05pm, V15 Nurse Practitioner stated the incident with R3 was avoidable and the facility must have not had R3 secured correctly in the sit to stand lift. V15 stated she definitely does consider R3's leg wound as harm as it was "deep" and was a "significant injury" that has not healed yet. V15 stated she saw R3 in the office and did order an antibiotic for her.

2. On 7/5/19 at 11:01am, V10 and V11 CNA's entered R4's room to transfer her with the sit to stand mechanical lift. After locking the wheelchair

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wheels, the CNA's instructed R4 to place her feet on the platform and lean forward so they could apply the lift sling about her waist. The sling was positioned about her waist and was not cinched snuggly as instructed in the handbook but hung loosely about R4's waist/lower chest area. As the CNA's lifted R4 off her wheelchair, they did not check the hooks, cinch the sling tighter or instruct her to lean back into the sling. The sling slid up under her armpits as they lifted R4 off her wheelchair and moved her to the bed.

R4's care plan dated 6/4/19 identifies her to have "impaired balance" and require a sit to stand machine transfer with two assists. A note dated 6/25/19 documents staff was educated on safe usage of the lift chair.

3. On 7/5/19 at 1:30pm, V12 and V13 CNA's entered R5's room to transfer her with a sit to stand mechanical lift. R5 was instructed to place her feet on the lift platform as the CNA's locked the wheels of her wheelchair. The CNA's then had R5 lean forward as they slid the sling down applying it over her breasts as they latched it. The sling was not located at the base of her spine. As the CNA's lifted R5 to a standing position, the sling slid further up under her arm pits. No instructions to lean back into the sling was given nor was any attempt made to ensure proper positioning of the sling prior to the lift.

The Care plan dated 5/23/19 document R5 to have impaired mobility and a congenital deformity of the feet. Interventions include a sit to stand transfer with the assist of two.

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