STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004352	A. BUILDING: _____ B. WING _____	C 02/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY NURSING PAVILION	9246 SOUTH ROBERTS ROAD HICKORY HILLS, IL 60457

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S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010b) 300.1210b)5) 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 300.1010 Medical Care Policies b) The facility shall have and follow a written program of medical services which sets forth the following: the philosophy of care and policies and procedures to implement it; the structure and function of the medical advisory committee, if the facility has one; the health services provided; arrangements for transfer when medically indicated; and procedures for securing the cooperation of residents' personal physicians.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 The medical program shall be approved in writing by the advisory physician or the medical advisory committee. 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. 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. 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.	S9999		

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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 are not met as evidenced by:

Based on observation, interview and record review the facility failed to provide a safe physical transfer for a resident according to the care plan and policies governing resident transfers. This applies to two of three residents (R1, R2) reviewed for injury, in a sample of three. This failure resulted in R1 sustaining a fracture to the upper left arm.

Findings include:

1.) R1's Physician Order Sheet (POS) dated 2/11/15 read "Schizo-affective disorder, diabetes mellitus, type I, cerebrovascular disease, cerebral artery occlusion, unspecified with cerebral infarction, traumatic amputation of leg, osteoarthritis, hyperlipidemia, depressive disorder, unspecified senile psychotic condition, esophageal reflux, anxiety state and acute pain due to trauma."

On 2/11/15 at 11:45am, R1 was observed sitting in a wheelchair with a cast on her left arm. The surveyor asked R1 what happened to her arm and R1 stated "I don't know." R1's primary language is Japanese. R1's left side of the body was paralyzed. R1 had the use of one leg due to an amputation of the leg.

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R1's care plan dated 9/4/14 reads "R1 has impaired ability to make self understood, and requires a one person assist for transferring." R1's Minimum Data Set (MDS) dated 12/4/14 under section G reads Transfer "Two person physical assist." Transfer is described as how resident moves between surfaces including to or from: bed, chair, wheelchair."

On 2/11/15 at 11:30am, E3 (Licensed Practical Nurse) stated that around 10:30pm on 2/5/15, E4 came out of R1's room and stated "I need you to look at R1's left arm." E3 stated R1's left paralyzed arm was red, swollen and there was a bone protruding. E3 stated she called Z1 (Physician). Z1 gave the order to send R1 to the hospital.

On 2/11/5 at 1pm, E4 (Certified Nursing Assistant) stated that he was taking care of R1 on 3-11 shift on 2/5/15. E4 stated he usually does not take care of R1. E4 stated he transferred R1 from wheelchair to bed by himself around 6:30pm. E4 grabbed underneath R1's right arm and around R1's waist to transfer R1 from wheelchair to bed. E4 stated that on his final rounds at approximately 10:30pm on 2/5/15, he noticed R1's left paralyzed arm was swollen and red. He saw a little bone popping out of her skin on R1's upper arm. E4 went to get the nurse and reported how R1's arm was reddened and swollen. E4 stated there was a bone protruding underneath the skin R1's left arm.
On 2/11/15 at 4:30pm, the surveyor asked E4 if he was aware that R1 is supposed to have 2 persons transfer her from wheelchair to bed. E4 stated he did not know that R1 was a 2 person transfer.

On 2/11/15 at 1:45pm, E6 (Nurse) stated that

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R1's arm was fine on day shift on 2/5/15. E6 stated that she saw R1's arm on 2/5/15 during the day shift and R1's arm did not have any redness, swelling or bone protruding underneath her skin.

R1's x-ray report from the hospital dated 2/6/15 reads "Spiral fracture of the distal humerus with posterior displacement and angulation of the distal fragment." R1 returned to the facility with a cast on her left arm.

On 2/11/15 at 4pm, Z1 stated that R1's spiral fracture of her left humerus could be the result of a transfer. The facility's accident report sent to the state agency dated 2/6/15 reads "Upon investigation possibly happened when CNA (Certified Nursing Assistant) was transferring R1 from wheelchair to bed."

2.) During the survey staff members were observed for techniques for transferring residents as follows:

-On 2/13/15 at 9am, E10 (CNA) was observed transferring R1 from the wheelchair to bed. E10 placed a gait belt around R1. The gait belt was not placed around R1's waist. The gait belt was placed around R1's upper Chest. E10 grabbed underneath R1's right arm while transferring R1 from the wheelchair to the bed. E1 (Director of Nursing) was in R1's room at the time of the transfer. E1 stated this is not correct transfer procedure. E1 stated , E10 should have placed her hands on the gait belt to transfer R1.

-On 2/13/15 at 9am, E10 (CNA) and E9 (Restorative CNA) transferred R2 from the wheelchair to the bed. E10 placed a gait belt around R2's waist. E10 and E9 grabbed underneath R2's arms and transferred R2 from

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S9999	Continued From page 5 the wheelchair to the bed. On 2/13/15 at 9:30am, E9 stated you should not grab underneath a resident's arm during a transfer. The facility's Lifting and Transferring Residents policy date 1/14 reads "Residents are lifted and transferred safely in all instances. Residents are assessed and determinations are made for lifting and transferring requirements and the procedure for each resident." The facility failed to follow R1's assessment for transferring noted in R1's 12/4/14 MDS (Minimum Data Set). The facility's Gait Belts for Transfer policy dated 2008 reads "Apply belt around resident waist. To transfer: Assist resident into a standing position by grasping belt at the waist from underneath. Pivot resident into chair or bed." The facility failed to follow its own policy for gait belt transfer for R1 and R2 on 2/13/15. (B)	S9999		