STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009443	A. BUILDING: _____ B. WING _____	C 06/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRI-STATE NURSING & REHAB CTR	2500 EAST 175TH STREET LANSING, IL 60438

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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 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	S9999		

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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)

Based on observation, interview, and record review the facility failed to perform a safe mechanical lift transfer according to the manufacture's instruction, ensuring arms were inside the lift sling, for 1 of 3 residents (R1) reviewed for reportable injuries in the sample of 3. As a result R1's left forearm became wedged underneath the wheelchair armrest while being raised by the lift, caused a jagged laceration measuring 5 centimeters (cm) long and 1.5 cm deep, and required transfer to the hospital for 7 stitches.

Findings include:

On 6/2/15 at 2:25pm, E4(Nurse) changed the dressing to R1's left forearm. R1 has a 5 cm jagged laceration with 7 stitches to the top of the left forearm approximately 3 cm above the wrist area.

On 6/2/15 at 3:05pm, E10(Nurse Aide) and E11(Nurse Aide) transferred R1 from the wheelchair to the bed using a mechanical lift. E11 instructed R1 to cross arms across her chest. R1 followed E11's directions without hesitation or reminders to keep them there.

Face sheet documents R1 was admitted to the facility on 12/17/08 and readmitted on 1/1/15. Initial Incident Report 5/28/15 2:22pm, documents R1 was noted with a skin tear to the

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left arm and an investigation is in progress. This initial report was faxed to the Illinois Department of Public Health on 5/28/15 at 2:09pm. Skin Integrity Event 5/18/15 documents R1 sustained a deep laceration to the left wrist measuring 3 x 0.5 cm, steri-strips were applied for a moderate amount of bleeding, the wound edges are irregular, R1 complains of moderate pain, and the physician was notified immediately for the large or deep skin tear/laceration with jagged edges needing sutures. Pain Observation 5/28/15 documents R1 complains of pain to a laceration on the left wrist.

Hospital Transfer Form 5/28/15 documents R1 was transferred to the hospital after sustaining a laceration on the left arm above the wrist from hitting arm on metal wheelchair during transfer from wheelchair to bed. Hospital Emergency Room records 5/28/15 document R1 sustained a laceration to the left forearm while being transferred from a wheelchair to the bed, cutting the forearm on metal on the wheelchair. Physical Examination picture documents a 1.5 cm laceration through skin and subcutaneous fat, muscle visible, fascia intact, wound margins serrated in many spots, laceration length 5 cm. Hospital Discharge Instructions 5/28/15 document 7 sutures to be removed in 10-14 days.

Final Incident Investigation 5/29/15 and faxed at 6:49pm, documents R1 sustained a laceration to the left forearm, physician and family were notified, first aid was given, and R1 was sent to the hospital. Staff interviews revealed "R1 was being transferred from the wheelchair to the bed with a mechanical lift, as R1 was being transferred with the mechanical lift and being raised, R1 grabbed the arm of the wheelchair and sustained a laceration to the left arm. R1's room

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and resident care equipment was assessed for hazard none observed." Employee In-service 5/29/15 documents E3(Nurse Aide) reviewed proper mechanical lift process and need for safe practices, return demonstration during the day while providing patient care. The investigation contains the initial and final report as described above, an unsigned statement on 5/28/15 from E4(Nurse) that E3 stated the laceration occurred when E3 transferred R1 from the wheelchair to the bed, and the care plan and E3 in service as described above.

On 6/2/15 at 11:35am, E3 stated on 5/28/15, R1's was being transferred from the wheelchair to the bed with E9(Nurse Aide) using a mechanical lift. R1's arm got stuck between the metal partition and underneath the armrest and R1 said "Don't break my arm" and "Ouch!" E3 stated the transfer continued and once R1 was in bed, E3 noticed something oozing onto R1's left shirt sleeve. E3 applied pressure and instructed E9 to inform E4.

On 6/2/15 at 11:55am, E2(Director of Nursing) stated that while R1 was being transferred from the wheelchair to the bed using a mechanical lift, R1 reached out for the wheelchair and sustained a cut to the left forearm. The wheelchair was inspected and nothing sharp was found that could have cut R1's arm, and do not know how it happened. E3 was inserviced that residents' arms need to be inside the sling during mechanical lift transfers.

On 6/2/15 at 2:45pm, E5(Restorative Nurse) stated E2 asked her to check R1's wheelchair for sharp edges that could have caused the laceration. E5 stated nothing sharp was found on R1's wheelchair that could have caused the laceration.

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S9999	Continued From page 4 On 6/2/15 at 2:50pm, Z1(Physician) stated the facility notified him that R1 sustained a laceration to the left forearm during a transfer from the wheelchair back to bed. R1 has fragile skin and it would not take a lot of force to break the skin when it comes in contact with metal. Z1 stated R1's laceration was jagged and not a smooth cut, caused from the force of pressure of something hard against the skin. The incident could have been avoided by using additional help to keep R1's arms inside the sling, stopping the transfer, or check on R1's position in the lift. On 6/4/15 at 9:20am by phone, E3 stated when R1 stated to not break her arm, E3 stopped the transfer, placed R1's left arm back inside the mechanical lift sling, and started to raise R1 again using the mechanical lift. When asked why E3 was stating something different today from 6/2/15, E3 stated "I had to think twice about what happened." E3 stated he spoke with E1(Administrator), E2, and Z2(Consultant) on 6/3/15 and E1 and Z2 "wanted to make sure what happened really happened" on 5/28/15. E3 stated R1 had a habit of reaching for things and it is E3's responsibility to make sure a resident's arms and legs are inside the mechanical lift sling during transfers. E3 stated E2 re-educated him on 5/29/15 on the proper and safe use of a mechanical lift, including keeping all body parts inside the cling during the transfer process. On 6/4/15 at 10:30am, E9 stated she did not see what happened when R1 yelled about her arm during the mechanical lift transfer. E9 stated the role of the second nurse aide during a mechanical lift transfer is to guide the sling carrying the resident, make sure the equipment is working and the patient is safe. One aide pushes	S9999		

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S9999	Continued From page 5 the lift while the other guides the sling with the resident in it. On 6/4/15 at 11:50am, E3 returned to the facility to demonstrate how R1's arm was positioned in relation to the wheelchair at the time of the injury on 5/28/15. E3 placed the left inside forearm with the left thumb facing upwards flush to the outside of the wheelchair at the level of the space between the upright metal partition and the underneath part of the armrest. E3 stated as the mechanical lift raised R1, R1's left forearm got wedged or "stuck" underneath the metal part of the armrest, applying pressure to R1's forearm. Manufacture documents for using a portable mechanical lift - To put the resident back to bed, you should instruct the resident to fold both arms over his or her chest. (B)	S9999		