Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012413	A. BUILDING: ______ B. WING ______	C 07/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANCISCAN VILLAGE	1270 FRANCISCAN DRIVE LEMONT, IL 60439

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S 000	Initial Comments Complaint 2174543/IL135444 F689 G cited	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b)5) 300.1210d)6) 300.3240a) 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. 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	S9999	Attachment A Statement of Licensure Violations	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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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 Regulations were not met as evidenced by:

Based on observation, interview and record review, the facility failed to safely transfer R1 between surfaces. The facility also failed to provide supervision to R2 during the use of the restroom.

This failure resulted in R1 sustaining a clavicle fracture and shoulder separation following an unsafe transfer, and R2 sustaining a left frontal traumatic subarachnoid hemorrhage/contusion.

This applies to 2 residents (R1, R2) reviewed for falls with major injury.

The findings include:

1. The EMR (Electronic Medical Record) shows R1 was admitted to the facility on April 7, 2021 and was discharged from the facility on June 16, 2021. R1 had multiple diagnoses including, anemia, coronary artery disease, hypertension, hip fracture, chronic kidney disease, history of falling, urine retention, dementia, and diabetes.

R1's MDS (Minimum Data Set) dated April 14,

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2021 shows R1 had moderate cognitive impairment, required supervision with eating, and extensive assistance with all other ADLs (Activities of Daily Living). R1 was frequently incontinent of bowel and bladder. R1's MDS continues to show R1 had a fall during the prior two to six months resulting in a fracture and one fall since admission to the facility resulting in injury.

On May 27, 2021 at 9:15 AM, V9 (RN-Registered Nurse) documented, "CNA reported that since Tuesday [5/25/21], resident has been weaker with her transfers. [R1] requiring [body sling] mechanical lift ..."

The facility's IDPH (Illinois Department of Public Health) Reportable Final Report dated June 15, 2021 for R1 shows: "On 6/9/2021 in the AM while providing ADL care, CNA (Certified Nursing Assistant) noted skin discoloration to right shoulder. Nurse on duty assessed [R1] and noted pain. CMS (Circulation, Motion, Sensation) to right arm was WNL (Within Normal Limits). MD was notified and orders received for X-ray. X-ray showed fractured right clavicle. On 6/10/2021, [V8] (NP-Nurse Practitioner) evaluated [R1] and asked her to be sent to hospital for further evaluation. Investigation showed that on June 3, while toileting resident that after being placed on toilet [R1] had difficulty using sit to stand [lift] and was weak to properly hold hand grasps and CNAs had to get a third person to assist them in getting [R1] back to bed. Investigation showed no fall, but they did have arm to arm placement under arms while third person used gait belt during transfer."

On July 7, 2021 at 11:42 AM, V3 (RN) said, "The CNAs had [R1] on a sit to stand mechanical lift

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from the toilet. They were having a hard time and called me in to help. The resident could not grasp the handrails on the sit to stand mechanical lift. The CNAs tried twice, and the second time, they lowered [R1] down to the toilet riser. She was totally asleep and unable to assist with the use of the sit to stand mechanical lift. We lifted the resident using the toilet riser to move her from the toilet towards her bed. We couldn't use the [body sling] mechanical lift because that lift would not fit through the bathroom doorway. Once we got next to [R1's] bed, each CNAs grabbed the resident under each arm, and I was holding [R1's] legs. She was very weak. Had we known she needed the [body sling] mechanical lift, we never would have put her on the toilet using the sit to stand mechanical lift. I talked to the family right away and they said they were surprised we used a sit to stand mechanical lift because they did not think [R1] could use that device. This all happened before breakfast on June 3, 2021."

On July 7, 2021 at 11:54 AM, V6 (Director of Therapy) said, "Every time a resident is transferred between surfaces, the resident needs to be assessed to see if the resident can tolerate being transferred and what is the most appropriate type of transfer device. This can change from day to day. If the resident is too weak to transfer, then the staff should use a [body sling] mechanical lift where a sling is placed under the resident's entire body and cradles the resident as they are lifted for the transfer between surfaces. This is the type of mechanical lift device we recommended for [R1] when she was discharged from physical therapy in late May 2021. [R1] was very inconsistent with transferring between surfaces at that time. I was never notified by facility staff that she had become increasingly weak the week prior to her injury and

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was consistently requiring the [body sling] mechanical lift for most transfers."

On July 8, 2021 at 11:27 AM, V8 (NP-Nurse Practitioner) said, "The nurse told me they lifted [R1] without the mechanical lift device and then the resident had bruising to her shoulder area a few days later. I ordered an X-ray that showed there was a fracture of her clavicle and possibly a shoulder separation. I ordered to send the resident to the emergency room."

On July 8, 2021 at 5:06 PM V18 (NP) and V19 (Orthopedic Surgeon) said, the mechanism of injury for R1's clavicle fracture and shoulder separation were directly related to R1's improper transfer and being improperly lifted under the arms.

2. On July 6, 2021 at 10:30 AM, R2 was self-propelling his wheelchair in his room. R2 could not recall his fall incident in April 2021. R2's left hand was curled inwards towards his abdomen and he was unable to use his hand. R2 appeared weak on his left side while self-propelling his wheelchair.

The EMR shows R2 was admitted to the facility in April 2016 with multiple diagnoses including cerebrovascular disease, traumatic hemorrhage of the cerebrum, left-sided hemiplegia, epilepsy, major depressive disorder, heart disease, right arm biceps injury, repeated falls, dementia with behaviors, atrial fibrillation, dysphagia, cognitive communication deficit, insomnia, anemia, and shortness of breath.

R2's MDS dated March 20, 2021 shows R2 is cognitively intact, requires supervision with eating, limited assistance with locomotion on the

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unit and personal hygiene, and extensive assistance with all other ADLs. R2 is frequently incontinent of urine and always continent of stool. R2's MDS further shows R2 has had one fall since admission/entry or reentry or prior assessment.

Facility documentation shows R2 has sustained falls at the facility on April 28, 2021, May 5, 2021, May 13, 2021, and June 5, 2021.

The facility's IDPH Reportable Final Report dated May 3, 2021 for R2 shows: "On 4/28/21, [R2] was transferred to the toilet in his room. CNA was outside room door and heard a loud noise. [R2] was on floor in the bathroom next to the toilet. ...After getting [R2] into chair, [R2] vomited yellow. At this time 911 was called. ...[R2] was sent to [local hospital[diagnosed with left frontal lobe favored to reflect a combination of subarachnoid blood and possible small hemorrhagic cerebral contusion."

Hospital documentation dated April 29, 2021 shows, "Presents ...following a fall at his nursing home, found to have a small L (Left) frontal TSAH/contusion (Traumatic Sub-Arachnoid Hemorrhage/contusion)."

On July 8, 2021 at 12:39 PM, V16 (RN) said, "[R2's] fall happened at 6:30 AM. [R2] is very impulsive. He has behaviors where he intentionally tries to hurt himself. The DON (Director of Nursing) told us not to leave him alone in the bathroom, that he's a two person assist. He's not supposed to be alone in the bathroom. That's something that has been in place for a long time. Obviously, the staff wasn't doing what they were supposed to be doing when they left him alone in there. He has fallen a lot,

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and it's usually because he doesn't follow directions, or being non-compliant. He has been difficult for the CNAs especially. He can only use one arm and one leg. He won't want to use a bedpan so it's tricky."

On July 12, 2021 at 11:40 AM, V20 (CNA) said, "I take care of [R2] all the time. During that incident on April 28, 2021, I had placed R2 on the toilet and left the bathroom. I was standing outside the door. I could not see the resident from where I was standing. I heard a thud that sounded like a potato sack hitting the floor. I ran to the bathroom and found him on the floor. He couldn't answer any questions I was asking him. He lost control of his bladder and had liquid stool after he fell on the floor. I had been told that a few days earlier he had a fall when he threw himself on the floor. I had taken care of him all the time. I left the bathroom just to give him some privacy. He didn't ask me to leave the bathroom. I just stepped out for his privacy. I did not see him fall off the toilet. He was lying on his left side when I found him."

On July 12, 2021 at 3:12 PM, V2 (DON) said, "Fall risk assessments were done for [R2] on March 4, 2021, and two times in April 2021. On March 4, April 14, and April 27, 2021, [R2] was assessed to be a high fall risk. He was being evaluated numerous times because he was having behaviors of banging his head on things like a lamp, and throwing himself on the floor during that time frame. He was expressing interest in assisted suicide and started trying to harm himself by throwing himself on the floor."

The facility's Incident Report Details for R2, dated April 28, 2021 shows: "During nursing report CNA called RN to resident's bathroom. Resident had

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S9999	Continued From page 7 apparently fallen from the toilet. Resident was unable to answer any questions re: pain or whether or not he had hit his head. There was no apparent injury seen. Upon getting him back to his WC (Wheelchair) he began vomiting. He is on Plavix (blood thinner). 911 called immediately. Cause Codes: Lack of/inappropriate supervision. Investigative Findings: Upon investigation resident was left alone on the toilet. He fell forward striking his head, resident was sent to ER for further evaluation." (A)	S9999		