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| S 000 | Initial Comments<br><br>Facility Reported Incident of 8/13/21/IL137272 F689G cited | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br><br>300.610a)<br>300.1210b)<br>300.1210d)6)<br>300.1220b)2)<br>300.3240a)<br><br>Section 300.610 Resident Care Policies<br><br>a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care | S9999 | Attachment A<br>Statement of Licensure Violations | |

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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:

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 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.

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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 Regulations were not met as evidenced by:

Based on observation, interview and record review, the facility failed to assess residents for the ability to safely operate power lift reclining chairs and develop and implement policies and procedures related to the operation/use of these power lift chairs. These failures affect two residents (R1, R2) who use power lift chairs. These failures resulted in R1's fall from the power lift reclining chair. R1 was found on the floor face down and was sent to the emergency room with a laceration requiring sutures and staples, severe neck pain and found to have acute fractures of C1/C2 cervical vertebrae. R1 admitted to Hospice upon return to the facility with a diagnosis of C1 fracture.

Findings include:

1. R1's Face Sheet dated 8/24/21 document R1's diagnoses including Displaced Posterior Arch Fracture of First Cervical Vertebra, Displaced Fracture of Second Cervical Vertebra, Palliative Care with date of onset of 8/13/21.

R1's Progress Notes dated 11/29/2020 document R1 has a history of Cerebrovascular Accident (CVA) with residual left arm Hemiplegia and left

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| S9999 | Continued From page 3<br>leg weakness.<br><br>R1's Progress Notes dated 1/29/21 document R1 has left side Hemiplegia.<br><br>R1's Brief Interview for Mental Status documents R1's Cognitive Status on 6/29/21 as moderately impaired.<br><br>R1's Incident Report dated 8/13/21 at 5:00am documents R1 was found on the floor of R1's room when an unidentified "Certified Nursing Assistant (CNA)" responded to R4, R1's roommate yelling for help. On arrival, V4, Registered Nurse (RN) noted R1 laying on R1's left side with the left side of R1's face to the floor and bleeding. R1 had a "Deep gash to left forehead with blood oozing out of it." V4 attempted to stop the bleeding by applying pressure but was unsuccessful and R1 was complaining of "severe neck pain." R1 stated R1 was attempting to raise R1's recliner but accidentally raised it too far and fell out of it. R1 also sustained a skin tear to the left forearm. This report also documents R1 is able to use the call light independently and last used the bedpan at 4:30am. R1 had been putting R1's right leg out of the bed and stated R1 needed to go somewhere so the staff placed R1 in R1's recliner with footrest up and remote in pocket of recliner. R4 had put the call light on and yelled out for assistance. R1 was noted face down on the floor and R1's recliner in an upright elevated position. R1 told V4, RN that R1 was leaning forward when using R1's recliner controller when R1 fell. R1 returned to the facility with a diagnosis of C1 and C2 spine with staples and sutures to the forehead and scalp. R1 was admitted to hospice on 8/13/21. | S9999 | | |

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| S9999 | Continued From page 4<br>There is no documentation R1 was assessed for the ability to safely operate the power lift reclining chair. There is no documentation R1 was provided education on how to operate the power lift reclining chair.<br><br>On 8/24/21 at 9:50am, V9, Consumer Call Center Representative for the lift chair company stated R1's power lift chair was discontinued in 2007. V9 stated the company would provide the company's basic manual for consumers. V9 stated R1 would have to be able to stand up and take steps independently to be safe to operate and properly use the power lift recliner. V9 stated R1 would have to be aware and have cognitive ability to safely operate the remote to the power lift chair.<br><br>R1's Care Plans dated 8/16/21 document R1 was "diagnosed with terminal illness: C1 fracture, and was admitted to Traditions Hospice on 8/13/21."<br><br>On 8/23/21 at 2:30pm, R1 was in lying in bed with eyes closed and use of accessory muscles were observed with breathing. There are two signs similar to each other on R1's wall directing staff to ensure R1's call light is attached to R1's clothing to help remind R1 to use it when R1 needs something. R1 had bruising to the left eye and a laceration extending towards top of head/scalp with a large bump and hematoma to the area and left side of R1's head.<br><br>On 8/23/21 at 2:50pm, V2, Director of Nursing (DON) stated the facility reviews and investigates the falls. V2 stated on 8/13/21, R1 was "confused" and told staff she wanted to go somewhere but didn't know where. R1 kept putting R1's right leg over the side of the bed and was restless so staff used a full mechanical lift to transfer R1 in to R1's power lift reclining chair. V2 | S9999 | | |

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stated V2 did not ask nor know if R1's call light had been attached to R1's clothing prior to staff leaving R1's room after transferring R1 in to the power lift reclining chair. V2 stated R1 has left side paralysis from a previous Cerebrovascular Accident (CVA) and is dependent on staff to transfer with a full mechanical lift. V2 was unaware if the chair had been evaluated or where the facility took R1's power lift reclining chair after R1's fall on 8/13/21. V2 stated V2 was unsure regarding other resident falls out of power lift chairs or if the facility had a policy and/or procedure on use of power lift chairs. V2 stated assessments for safety of use of power lift reclining chairs are in the Restorative Assessments for each resident.

The Basic Operation Manual is dated April 2021 and documents the intended use of this device is that of a device with motorized positioning control that is intended for medical purposes and that can be adjusted to various positions. The device is used to provide stability for patients and to alter postural positions. This device will provide lift assistance for people who have difficulty rising from a seated position to a standing position. This manual also documents, "WARNING! Do not attempt to stand up until you can stand safely, are steady on your feet, and can bear weight. We recommend the use of assistance aids and/or an attendant for enhanced stability."

The undated Guidelines for Nursing Homes, Ergonomics for the Prevention of Musculoskeletal Disorders documents, "OSHA (Occupational Safety and Health Administration) Description: Lift cushions and lift chairs. When to Use: Transferring residents who are weight-bearing and cooperative but need assistance when standing and ambulating. Can be used for

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| S9999 | Continued From page 6<br>independent residents who need an extra boost to stand. Points to Remember...Lift chairs are operated via a hand-held control that tilts forward slowly, raising the resident. Residents need to have physical and cognitive capacity to be able to operate lever or controls.<br><br>2. R2's Minimum Data Set (MDS) dated 6/24/21 documents R2 has a short term memory problem and has behaviors of inattention and altered level of consciousness.<br><br>R2's Minimum Data Set (MDS) dated 6/24/21 documents R2 requires supervision of one staff member for transfers.<br><br>R2's Incident Report dated 8/15/21 at 9:09am documents R2 was found on R2's buttocks in front of R2's lift reclining chair with the chair in the upward/raised position. R2's blanket was laying next to R2 on the floor. R2 stated R2 was trying to get up from R2's chair and slid on to R2's buttocks. This report documents V10, Licensed Practical Nurse (LPN) heard R2 yelling from R2's room and found R2 positioned on R2's buttocks in front of R2's chair. This report documents R2 is independent in R2's room using R2's rolling walker and that the Restorative program would assess resident abilities to reposition recliner correctly.<br><br>R2's Progress Notes dated 8/16/21 document R2 was "in-serviced" on the proper ways to operate R2's lift chair. R2 stated R2 knows how to operate it but R2 had pushed the wrong button. There is no further explanation regarding what button R2 was trying to push or what "ways" were included in R2's education related to operating the lift chair. There is no documentation the manufacturer's manual was used to educate R2. | S9999 | | |

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| S9999 | Continued From page 7<br>There is no documentation prior to R2's fall that R2 had received education on safe operation/use of the power lift chair.<br><br>On 8/24/21 at 9:24am, V1, Administrator stated the facility was unable to find an operation manual/guidelines for use of the power lift chairs that were in the facility being used by residents. V1 also stated the facility does not have a policy/procedure in place regarding assessing for resident's ability to operate the power lift chair safely or education for residents regarding power lift reclining chair use.<br><br>On 8/24/21 at 9:50am, V9, Consumer Call Center Representative for the lift chair company stated the remote should not be placed in the seat when not in use and should be locked/disconnected when not in use. V9 stated the company would provide the company's basic manual for consumers. V9 stated R2 would have to be aware and have cognitive ability to safely operate the remote to the power lift chair.<br><br>On 8/24/21 at 1:35pm, R2's power lift reclining chair was positioned up/elevated off the floor with the remote placed on the seat of the chair.<br><br>On 8/25/21 at 3:00pm, V2, DON stated the root cause of R2's fall was R2's inability to safely operate the power recliner controller.<br><br>(A) | S9999 | | |