STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003115	A. BUILDING: _____ B. WING _____	C 06/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FARMINGTON COUNTRY MANOR	701 SOUTH MAIN STREET FARMINGTON, IL 61531

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S 000	Initial Comments Facility-reported Incident Investigation to incident date of 6/7/21/IL134792. Licensure Findings:	S 000		
S9999	Final Observations Facility Reported Incident of June 7, 2021, IL134792 STATEMENT OF LICENSURE FINDINGS: 300.1210d)6) 300.1210c) Section 300.1210 General Requirements for Nursing and Personal Care 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 300.1210 General Requirements for Nursing and Personal Care c)Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. These regulations were not met as evidenced by:	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 Based on interview and record review, the facility failed to ensure a resident was transferred according to their plan of care for one (R1) of three residents reviewed for transfers in a sample of three. This failure resulted in R1 sustaining a femur fracture and increased pain. Findings include: Facility "Safe Lifting and Movement of Residents," dated 1/1/16, documents "In order to protect the safety and well-being of staff and residents, and to promote quality of care, this facility uses appropriate techniques and devices to life and move residents." R1's facesheet documents R1 was Admitted on 5/24/21 and Re-admitted from the hospital on 6/10/21. R1's medical record documents under her current diagnoses the following: "Osteoarthritis, weakness, fracture of left femur (9/12/20), Chronic inflammatory demyelinating polyneuritis (Autoimmune disease that affects the nerves in the arms and legs)." R1's careplan documents an onset date of 5/24/21 for the following: "I am unable to transfer independently, and I am a two assist and hoyer lift for all transfers due to declining disease process and weakness." R1's MDS (Minimum Data Set), dated 5/31/21, documents R1 is cognitively intact, and requires total assistance of two for transfers. On 6/15/21 at 1:40pm, R1 was in her bed with a trapeze over the bed, hoyer sling in her	S9999		

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S9999	Continued From page 2	S9999		

wheelchair, right leg in an immobilizer, and was alert and oriented. On the inside of R1's closet door, R1's "carecard" posted in R1's closet, dated 5/25/21, documents R1 is "Alert and oriented, non-ambulatory, uses a wheelchair is a (total) lift with an assist of two. Staff assist of two with (total lift) for all transfers and hospice." There was also a note posted in capital letters and bold face in R1's closet, no date, documents "Resident is to be staff assist x2 for all cares and transfers- no exceptions!!! Resident is to be a hoyer lift at all times with staff assist of two." At that same time, R1 stated "One CNA (V3 Certified Nurse Aid) transferred me by herself without a lift and it was supposed to be two people with the lift. (On 6/7/21), I was sitting at the edge of the bed and (V3 CNA) put me in the wheelchair by herself. I did not have pain right away; it took a while for the pain to come and when it did it was bad. I got pain meds and an X-Ray for my right leg. They had always used two people and used the lift with me prior to (6/7/21)."

R1's "Resident Incident Report," dated 6/7/21, documents "(R1) states she was transferred without a hoyer, pain to right knee, non-pitting edema, and redness to knee without heat."

R1's "Incident Investigation," dated 6/7/21 by V7 RN (Registered Nurse), documents "CNA (V3 Certified Nurse Aid) transferred (R1) to the wheelchair and then (R1) started having pain in her right leg and knee area. Tried to reposition (R1) without success. Hospice nurse, CNA, and floor nurse transferred (R1) back to bed to assess (R1). (R1's) right knee is more swollen than the left and (R1) complains of pain with Morphine given. Hospice nurse instructed (V7) to get an X-Ray and if (R1) continued to have pain which (R1) did. X-ray done and showed a fracture

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S9999	Continued From page 3	S9999		

of the distal femur. (R1's) medical doctor gave orders to keep (R1) comfortable for the night and if pain not controlled to send (R1) to the ER (Emergency Room)."

R1's "Incident Investigation" notes, dated 6/8/21 by V2 DON (Director of Nursing), documents "Assessed (R1's) right leg and her right knee is more swollen than the left. (R1) has intense pain with any kind of attempted movement. (R1) decided she would go to the ER and was sent by ambulance to (local) hospital. (R1) was admitted to the hospital with an ortho consult the next day. After interviewing staff and talking with the staff member (V3 CNA) that transferred (R1) inappropriately, I informed (V3) that she was suspended until my investigation was finished." This form further documents V2 DON re-educated staff on transfers and resident care cards.

V3's employee file has a document titled "Employee Warning Report," dated 6/7/21, which documents "On 6/7/21 at 10:50am you transferred (R1) inappropriately and caused her pain." This form further documents on 6/8/21, V3 was put on immediate suspension, V3 did not come in to sign the form, and V3 did not do a witness statement but acknowledged the suspension through text messages.

R1's "Long-term care- Serious Injury Incident Report", dated 6/9/21 by V2 DON (Director of Nursing), documents "(R1) is interviewable, makes informed decisions, alert and oriented, and R1 had an incident on 6/7/21 where an assessment was performed on 6/7/21 at 12pm. (R1) was sent to the hospital ER (Emergency Room) on 6/8/21 at 1:45pm for an X-Ray where R1 got the diagnosis of a "closed fracture of distal

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end femur of the right leg." Ortho was consulted and ordered an immobilizer to R1's right leg, continue pain control, and non-weight bearing to right leg. I have discussed with staff about her transfers, positioning, and activity of daily living."

R1's hospital notes from (local) hospital, dated 6/8/21 at 3:11pm documents "(R1) presenting to the Emergency Department for evaluation of leg pain. Patient states she is normally moved by hoyer at the nursing home but states a staff member physically lifted the patient yesterday (6/7/21). Patient denies falling and is complaining of right leg pain, pain is present in the right thigh, nothing relieves the pain, and tenderness to the entire right femur."

R1's hospital X-Ray, dated 6/8/21 at 4:59pm, documents "The patient has a mildly impacted transverse distal femoral shaft fracture."

R1's Orthopedic Consultation note, dated 6/9/21 at 8:09am, documents "R1 is 91 years old, recommend conservative treatment at this time. Knee immobilizer to the right lower extremity."

R1's nurses notes document the following: On 6/3/21 R1 had no complaints of pain, was on hospice, and transferred by a lift; on 6/7/21 R1 was to be discharged from hospice on 6/10/21; on 6/7/21 at 5:39pm R1 complains of pain to right knee, right knee area is edematous and red, Tylenol #3 given but not effective for pain, Morphine 5mg given for pain, x-ray notified for x-ray of right knee/tibia/fib; X-ray report documents R1 has a "Transverse, displaced supracondylar fracture of the distal femur"; on 6/8/21 at 4:27am and 5:22am R1 complained of pain to right leg, and right leg from knee down edematous and painful to the touch; on 6/8/21 at

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S9999	Continued From page 5 3:13pm R1 continued to have swelling and increased pain, and R1's daughter here and they decided to go to (local) hospital for evaluation and treatment; and on 6/10/21 at 2:20pm, R1 was admitted back to the nursing home with a fractured distal right femur with her right leg in a binder. On 6/15/21 at 12:10pm, V2 DON stated "(R1) did not have a fall, her leg got twisted and fractured from a transfer. She was on hospice at the time, (R1) did not want to go to the hospital, daughter came in the next day and talked to (R1) and (R1) agreed to go to the hospital ER for an evaluation. A CNA (V3) transferred (R1) by a stand pivot but (R1) did not pivot when (V3) put (R1) into the wheelchair. (R1) was a hoyer with two-person transfer but was transferred by one-person assist. After my investigation I immediately suspended (V3). (R1) went to the hospital, got diagnosed with a femur fracture, and came back (to the nursing home) with a knee immobilizer. (R1) has needed to take pain medication since the incident. All residents have carecards in their closets, so the staff know how to transfer residents, (V3) knew how (R1) transferred, and the carecards have been used here for years." On 6/15/21 at 12:40pm, V7 Registered Nurse/RN stated "I worked on 6/7/21 and was told (R1) was having pain to her right knee by (R1's) hospice nurse. I don't know what happened to (R1's) knee, but we did hoyer transfer her back to bed with three people and I assessed her. I gave her pain medication because her right knee was edematous, red and she was complaining of pain. I gave her Tylenol #3 and Morphine. (R1) does not bear any weight, and she was a two-person hoyer lift on 6/7/21."	S9999		

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S9999	Continued From page 6 On 6/15/21 at 12:45pm, V8 CNA stated "I worked 6/7/21 and I got (R1) ready for the day and left her in bed for breakfast per her request. I did not see her until later when the nurse wanted her put back to bed. When I came to help her back to bed, she was in the wheelchair with no hoyer pad under her and I thought that was odd because we leave the hoyer pads under residents when we transfer them because it is easier to transfer them again. I had the nurse help me put the hoyer pad under her so we could transfer her back to bed. It was me, the nurse (V7), and the hospice nurse in the room when we transferred her back to bed with the hoyer, she told the nurses she was in pain, and I left the room. I would have helped (V3) if I had known she needed help with (R1)." On 6/16/21 at 8:50am, V9- R1's family member stated "I noticed (R1's) leg was swollen when we had our visit that Monday (6/7/21). I was told a CNA transferred (R1) by herself and did not use two people and the lift which she has been using since she got to the nursing home." (B)	S9999		