STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000210	A. BUILDING: _____ B. WING _____	C 10/25/2021

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ACCOLADE HEALTHCARE DANVILLE	801 NORTH LOGAN AVENUE DANVILLE, IL 61832

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S 000	Initial Comments Facility Reported Incident of 10/14/21/IL139488	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1210b)5) 300.1210c) 300.1210d)6) 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. 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.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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. These requirements were not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure a resident (R1) was transferred in accordance with the resident's plan of care. This failure resulted in R1 being sent to the local emergency room with a left knee laceration that required nine sutures to close the laceration. The facility also failed to develop and implement interventions to prevent reoccurrences of skin injuries for two of three residents (R2, R3) reviewed for skin injuries in the sample list of three.	S9999		

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S9999	Continued From page 2 Findings include: The facility's Accidents and Incidents policy revised March 2021, documents the following: "All accidents/incidents involving a resident, visitor or volunteer will be investigated, and then recorded on the Confidential Accident/Incident Report Form." "It is the responsibility of the D.O.N. (Director of Nursing)/Designee to investigate and ensure appropriate completion, notification, and follow-up on all Accidents and Incidents." "The Charge Nurse must conduct an immediate investigation of the accident/incident and implement immediate appropriate interventions to affected parties." "The D.O.N./Designee will conduct an investigation of the accident/incident as well. Findings will be indicated on the Accident/Incident Report Form in appropriate area." "The IDT (Interdisciplinary Team) will be notified of the accident/incident so that appropriate changes may be made to the care plan as needed." 1. R1's Incident Report dated 10/14/21, documents at 4:40 AM R1 had a left knee laceration. R1 was alert and oriented to person, situation, and place. V3 Agency Certified Nursing Assistant (CNA) Witness Statement documents V3 sat R1 on the side of the bed, and stood and pivoted R1 into the wheelchair. R1 was transported to the shower room and R1 complained of left knee pain. V3 noticed blood and R1's left knee injury. R1's Hospital Notes dated 10/14/21 at 5:44 AM, documents R1 was seen in the emergency room for a laceration to the left knee that was caused during a transfer from the wheelchair to the bed. R1's laceration was 7 centimeters long, had significant loss of tissue requiring undermining of	S9999		

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S9999	Continued From page 3 the skin to approximate the wound edges, and required 9 sutures to close the laceration. R1's Minimum Data Set (MDS) dated 9/15/21 documents: R1 is dependent upon two staff for transfers. R1 is not steady and requires staff assistance to stabilize R1 when moving from seated to standing positions and during surface to surface transfers. R1's Care Plan with a revision date of 4/8/21, documents R1 is at risk for falls secondary to Cerebrovascular Accident with left sided weakness. R1's Care Plan revised on 3/26/21 documents R1 requires assistance with Activities of Daily Living related to Activity Intolerance, Confusion, Dementia, Impaired Balance, Spinal Stenosis, and Osteoarthritis of bilateral knees. This Care Plan documents an intervention revised on 1/21/21 that R1 requires a full mechanical lift and two staff for transfers. R1's Interview dated 10/15/21 recorded by V2 DON documents: R1 stated the CNA (V3) put R1's legs on the side of the bed and transferred R1 into the wheelchair. R1 stated a lift was not used during R1's transfer. The facility's Report to Illinois Department of Public Health dated 10/21/21 documents a summary of R1's incident as follows: R1's laceration occurred during the transfer from the bed to the wheelchair. R1 was sent to the local emergency room for treatment and received nine sutures to the laceration. Maintenance noted that a screw was sticking out of R1's wheelchair which potentially caused R1's injury, and padding was applied to R1's bed frame and wheelchair. The CNA (V3) stated R1 was transferred by standing and pivoting from the bed to the wheelchair.	S9999		

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S9999	Continued From page 4 Transfer education was provided to nursing staff. On 10/25/21 at 11:47 AM R1 was sitting in a wheelchair with a full mechanical lift sling positioned underneath of R1. R1 stated: About a week ago around 4:00 AM, a CNA came in and got R1 out of bed. The CNA self-transferred R1 and did not use a mechanical lift. R1 bumped R1's left knee during the transfer, causing a wound to R1's knee. R1 was transferred to the hospital for stitches. On 10/25/21 at 3:09 PM R1's left knee wound was observed with V10 Licensed Practical Nurse (LPN.) R1's wound sutures were intact. On 10/25/21 at 12:25 PM V3 Agency CNA stated: V3 sat R1 on the side of the bed (on the morning of 10/14/21), and assisted R1 to stand and pivot from the bed to the wheelchair. V3 took R1 to the shower room and R1 complained of knee pain. V3 noticed R1's left knee injury and reported to V7 Licensed Practical Nurse (LPN.) That was the first time V3 was assigned to give R1 a shower and the first time V3 had transferred R1. Usually a CNA lets us know how residents transfer. V3 was not aware that R1 required two staff and a mechanical lift for transfers. On 10/25/21 at 12:42 PM V3 stated R1 seemed "heavy" during the transfer, and R1 was not standing well. When V3 pivoted R1 into the wheelchair R1's buttocks hit the armrest of the wheelchair before V3 could get R1 onto the seat. If a mechanical lift was used, R1 wouldn't have had mobility of R1's legs and the injury may have been prevented. On 10/25/21 at 2:33 PM V7 LPN stated: During the morning of 10/14/21 V3 notified V7 that R1 was bleeding from R1's knee. R1 had blood running down R1's leg and a puddle of blood was on the floor. R1's left knee had about a 1 inch	S9999		

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S9999	Continued From page 5 gash, that was deep, and more than a skin tear. R1 was sent to the hospital and the wound required stitches. V7 traced drops of blood from the shower room to R1's room. V3 was the CNA who had transferred R1 out of bed. No other staff assisted with R1's transfer and V3 did not use a mechanical lift during the transfer. R1 should have been transferred with a full mechanical lift. On 10/25/21 at 12:40 PM V8 Nurse Practitioner stated: V8 would expect staff to follow the resident's transfer status. Agency staff may not know how a resident transfer, but they should be informed. R1's injury probably would have been prevented if the proper lift and transfer status was used. On 10/25/21 at 2:45 PM V2 Director of Nursing stated: Staff are to review the resident's electronic file to determine resident transfer status. The resident's file pulls information from the resident's care plan. Staff are expected to always follow the resident's care plan for transfer status. An all staff in-service was conducted following R1's injury on how to locate and review the resident's file. Sometimes agency staff don't review the resident's file, so we are in the process of implementing laminated cards with the resident's transfer status. The cards will be placed in resident rooms, so staff know how each resident transfers. The root cause of R1's injury was that R1 was improperly transferred by V3 CNA. The facility identified a screw was inserted the wrong way with the end sticking out of the leg rest of R1's wheelchair, causing R1's laceration. R1's injury could have been prevented if R1 was transferred with a full mechanical lift as R1 would have been positioned above the chair and would have avoided contact with the screw. R1 was believed to have grazed the screw during the	S9999		

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S9999	Continued From page 6 stand/pivot transfer. The location of the screw aligned with the location of R1's injury. 2. R2's MDS dated 8/19/21 documents: R2 has short- and long-term memory impairment and requires extensive assistance of two staff for bed mobility, transfers, dressing, and toileting. R2's Nursing Notes document: On 7/22/21 at 6:07 AM, R2 had a skin tear to the right forearm/antecubital that measured 5 centimeters. R2 was combative during incontinence care, attempted to grab staff, and grabbed R2's own arm causing the skin tear. On 8/17/21 at 6:27 AM CNAs were changing R2, and R2 was fighting and hitting the staff. R2 received a large skin tear to the left arm near the elbow, and one on the right wrist. R2's nursing notes do not document interventions were implemented following R2's skin tears. R2's Care Plan with a revision date of 8/17/21 documents: R2 is at risk for impaired skin integrity. On 7/20/21 R2 had a skin tear to the right antecubital during cares. On 8/16/21 R2 had a skin tear to R2's left arm and left wrist. R2's care plan does not document interventions were developed and implemented after R2's skin tears to prevent reoccurrences of skin injuries. R2's Incident Report dated 7/22/21 at 5:59 AM documents R2 received a skin tear during incontinence care when R2 grabbed R2's own forearm causing a 5-centimeter skin tear. This report does not document an investigation of R2's injury was completed, or interventions were developed/implemented to prevent reoccurrence of skin injuries. R2's Incident Investigation dated 8/17/21,	S9999		

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S9999	Continued From page 7 documents R2 had a skin tear to the left elbow and right wrist. Two CNAs were attempting to provide cares when R2 became physically aggressive with staff. The CNAs were given verbal reminders to stop care when R2 becomes agitated, allow R2 to calm down and reattempt to provide care for R2. The facility's Incident Log dated 7/1/21-10/25/21 does not document R2's skin tear on 8/17/21. On 10/25/21 at 2:46 PM V14 CNA stated: R2 has Dementia, and we explain and provide cues to R2 during cares. V14 was not sure of any other interventions used to prevent skin injuries for R2. R2 has gotten skin tears. Sometimes R2 bumps the siderails of R2's bed. 3. R3's MDS dated 10/5/21 documents: R3 has severe cognitive impairment and requires extensive assistance of one staff for bed mobility and dressing, and two staff for transfers and toileting. R3's Care Plan with a revision date of 10/12/21 documents: R3 had a skin tear to the left hand on 9/20/21. R3's care plan does not document interventions were developed/implemented after R3's skin tear to prevent reoccurrences of skin injuries. R3's Incident Report dated 9/21/21 at 5:22 AM documents: R3 had dried blood on the bed sheet and a skin tear to the back of R3's left hand between the thumb and first finger. R3's Nursing Note dated 9/21/21 at 5:35 AM documents dried blood was found on R3's bed sheet and a skin tear were noted to the back of R3's left hand. R3 was unable to say how the skin tear occurred. There is no documentation that interventions were developed/implemented to prevent	S9999		

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S9999	Continued From page 8 reoccurrences of skin injuries. On 10/25/21 at 1:28 PM V4 CNA stated V4 was not sure what interventions were used for R3 to prevent skin injuries. On 10/25/21 at 3:40 PM V2 DON stated: Following skin injuries a risk management incident form is completed by the nurse. The nurse should document facts such as if the resident was attempting to self-ambulate at the time the injury was noted. New interventions should be implemented following skin injuries. Interventions are to be documented on the risk management form or on the resident's care plan. V2 was unable to provide documentation that R2's skin tear on 7/22/21 and R3's skin tear on 9/21/21 were investigated and interventions were developed/implemented to prevent reoccurrences. (B)	S9999		