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	IL6003578	A. BUILDING: _____ B. WING _____	C 11/01/2021

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S 000	Initial Comments Facility Reported Incident of 10/17/21/IL139625	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1010h) 300.1210a) 300.1210b) 300.1210c) 300.1210d)2) 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 and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.	S9999		

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S9999	Continued From page 2 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: 2) All treatments and procedures shall be administered as ordered by the physician. 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 Regulations are not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure a resident (R1) was transferred per the resident's assessment and facility policy and failed to ensure R1 was wearing physician ordered compression stockings. These failures resulted in R1 being sent to the local emergency room with a right lower leg laceration that required 17 sutures to close the laceration. The facility also failed to prevent a resident (R3) injury by failing to replace a broken toilet tank lid resulting in R3 being sent to the local emergency room with a left index finger laceration that required 4 sutures to close the laceration. R1 and R3 are two of three residents reviewed for injuries in the sample list of three. Findings include: The facility's Safe Lifting and Movement of Residents policy revised October 2009	S9999		

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documents: "1. Resident safety, dignity, comfort and medical condition will be incorporated into goals and decisions regarding the safe lifting and moving of residents. 2. Manual lifting of residents shall be eliminated when feasible. 3. Nursing staff, in conjunction with the rehabilitation staff, shall assess individual residents' needs for transfer assistance on an ongoing basis. Staff will document resident transferring and lifting needs in the care plan."

1. The facility's Final Investigation Report dated 10/22/21 documents: On 10/18/21 at 8:30 AM R1 was transferred from the wheelchair to the bed by attending aide (V6 Agency Certified Nursing Assistant (CNA)), and R1's right lower leg bumped against the wheelchair causing a laceration. R1 was sent to the local emergency room and received 17 sutures to close the laceration. "The clinical record confirm that this resident (R1) has bilateral 4 + pitting edema (indicating a deep indentation lasting more than 20 seconds)." R1's Hospital Discharge Summary dated 10/18/21 documents R1 was evaluated for a laceration of the right lower leg and R1 received 17 stitches to close the laceration.

R1's Diagnosis List dated 11/1/21 documents R1 has diagnoses of Legal Blindness, Anxiety, and Unspecified Intellectual Disabilities. R1's Minimum Data Set (MDS) dated 10/5/21 documents R1 has moderate cognitive impairment and requires extensive assistance of at least two staff for transfers. The MDS documents for chair/bed to chair transfers. R1 is dependent, meaning the helper does all of the effort and the resident does no effort in completing the activity, or the assistance of 2 or more staff is required to complete the activity.

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S9999	Continued From page 4 R1's Care Plan dated 6/30/21 documents R1 requires assistance with Activities of Daily Living (ADLs) including transfers. This care plan documents an intervention dated 10/20/21 to transfer R1 with a full mechanical lift. R1's Care Plan dated 10/21/21 documents R1 is dependent on two staff and a full mechanical lift for transfers. R1's Care Plan does not document R1's transfer status or the amount of assistance R1 needed with transfers prior to 10/20/21. R1's Nursing Notes document on 10/8/21, 10/11/21, 10/12/21, 10/14/21, and 10/15/21 document R1 requires total care for ADLs and uses a full mechanical lift for transfers. R1's Restorative Nurse Screener Evaluation dated 10/6/21 documents R1 requires "substantial/maximal assistance" for chair/bed to chair transfers. R1's Order Summary Report dated 11/1/21 documents an order started on 8/10/21 to apply compression stockings to bilateral lower extremities in the morning and remove at night to reduce edema. R1's Wound Evaluation & Management Summary by V29 Wound Physician dated 10/21/21 documents R1's right, anterior, lateral leg laceration with stitches measured 10 cm (centimeters) long by 5 cm wide and an order to apply a nonadherent dressing covered with a gauze sponge daily. There is no documentation in R1's medical record that R1 refused to wear R1's compression stockings on 10/18/21. V6's Witness Statement dated 10/21/21 documents on 10/18/21 (R1) "was sitting in (R1's) w/c (wheelchair). I (V6) put (R1's) pedals to the sides, positioned (R1's) legs between mine. (V6) put (V6's) arms underneath of (R1's) arms and stood (R1) up and transferred (R1) to the bed.	S9999		

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Rolled w/c back, noticed that (R1's) (R) (Right) LE (Lower Extremity) was bleeding. (V6) asked housekeeper to call for help. (V6) lifted (R1's) legs onto bed. Nurse arrived."

V6's Just-In-Time Training dated 10/18/21 documents V6 received training to follow the resident's care plan when transferring residents. The care plan can be viewed in (Electronic Medical Record System) or ask the nurse or CNAs. V6 is expected to ask if V6 is unsure how to transfer a resident.

On 11/1/21 at 8:47 AM V6 and V7 CNA's transferred R1 from the wheelchair to the bed with a full mechanical lift. R1's lower legs were swollen, and R1 was not wearing compression stockings. R1 had a dressing covering R1's right lower leg laceration that was saturated with blood-tinged drainage, and the drainage had seeped onto R1's right lower pant leg. V7 confirmed R1 was not wearing compression stockings. V7 stated night shift had gotten R1 dressed and into the wheelchair. On 11/1/21 at 10:14 AM V9 Licensed Practical Nurse (LPN) changed R1's right lower leg laceration dressing. R1's sutures were intact, and the surrounding skin was red and black.

On 11/1/21 at 8:39 AM V6 Agency CNA stated: On the day of R1's injury, V6 transferred R1 from the wheelchair to the bed. V6 locked the wheelchair and pushed the foot pedals to the side. V6 used a gait belt to stand R1 and pivot R1 to the bed. R1 partially stood during the transfer. When V6 lifted R1's legs into bed V6 noticed blood and a cut on R1's leg. R1 was wearing really tight jeans and did not have on compression stockings. R1 is supposed to wear compression stockings, but night shift had

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already gotten R1 dressed and in the wheelchair that morning. V6 was told that R1 was supposed to be transferred with a full mechanical lift, and V6 should check the resident's care plan or ask a nurse for transfer status prior to transferring a resident. V6 does not work on R1's hallway often, so V6 did not know R1 was to be transferred with a full mechanical lift. V6 was told that R1 bumped R1's leg on part of the wheelchair during the transfer causing the laceration.

On 11/1/21 at 12:20 PM V2 Director of Nursing (DON) stated a full mechanical lift for transfers is the new intervention implemented after R1's injury. V2 believes R1's leg hit the wheelchair during the stand and pivot transfer causing the laceration. The CNAs were educated on how to locate the Kardex and resident transfer status, the facility is still adjusting to the new (Electronic Medical Record) system. V3 Assistant DON stated prior to R1's injury at times two staff were used to transfer R1, and staff can always downgrade a resident to use a full mechanical lift if the resident is having difficulty with transfers. V3 stated, "I believe we are all on the same page now and (R1) is to use a (full mechanical lift) for transfers." On 11/1/21 at 12:41 PM V2 and V3 confirmed R1's care plan does not document R1's transfer status prior to 10/20/21 when it was updated to use a full mechanical lift for transfers. V2 stated: R1's Care Plan documented to assist with transfers but did not document the amount of assistance R1 needed. The Care plan is where staff look to determine a resident's transfer status.

On 11/1/21 at 2:33 PM V11 LPN/Restorative Nurse stated: V11 completes transfer, ADL, and restorative assessments that transfer to the MDS. V11 viewed R1's Restorative Nursing Screener

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dated 10/6/21 and MDS dated 10/5/21. V11 stated at the time V11 completed the evaluation, V11 gathered information from the CNAs. An unidentified CNA told V11 that R1 was substantial/maximal assistance for transfers, which means R1 needed two staff to complete the transfer. V11 stated R1's MDS documents for chair/bed to chair transfer R1 is dependent, which means R1 was totally dependent on staff and a full mechanical lift is used.

On 11/1/21 at 2:52 PM V16 Nurse Practitioner stated: R1's right leg laceration would be consistent with R1 bumping R1's leg on the wheelchair during a stand and pivot transfer. R1 had to have a "bunch" of stitches to close the laceration. Compression stockings would have provided an extra layer of protection for R1's skin. If the facility has the staff, they should be using two staff to transfer R1, and the injury probably could have been avoided.

2. The facility's Final Investigation Report dated 11/1/21 documents: On 10/23/21 at 12:30 PM R3 was observed in another resident's room with blood on R3's clothing. R3 had a cut to the left greater finger and was sent to the local emergency room where R3 received 4 sutures. The lid of R3's toilet was found chipped. "Resident (R3) has a history of impulsiveness and is unaware of safety measures. Resident (R3) is believed to have cut (R3's) finger on the toilet lid and walked to other resident's room. The toilet lid was replaced immediately."

R3's Hospital Nursing Notes dated 10/23/21 document R3 arrived at the emergency room with a 2 cm (centimeter) laceration to the crease of the left index finger. The laceration was closed with 4 stitches.

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R3's Diagnosis List dated 11/1/21 documents R3 has diagnoses including Epilepsy, Deaf, and Legal Blindness. R3's MDS dated 8/20/21 documents R3 has highly impaired hearing and severely impaired vision and requires extensive assistance of one staff person for transfers and walking in R3's room.

R3's Care Plan dated 10/21/21 documents: R3 transfers with assistance/supervision of one staff person related to hearing and vision deficits. R3 wanders into other resident rooms looking for a place to go to the bathroom. Redirect R3 back to R3's room, wheelchair, or bed.

On 11/1/21 at 10:06 AM R3's left index finger was observed with V9 LPN. There were no stitches in place. V9 stated R3's stitches were removed on 10/31/21.

On 11/1/21 at 10:31 AM V17 Maintenance stated: Staff notified V17 last week that R3 had a cracked toilet tank lid. The lid appeared as though it had been dropped and cracked. V17 replaced R3's toilet tank lid the same day it was reported to V17. On 11/1/21 at 10:44 AM V17 stated: V17 was notified on 10/25/21 about R3's cracked toilet lid. Prior to that day, no one had reported to V17 that R3's toilet lid was broken.

On 11/11/21 at 10:36 AM V8 CNA stated: V8 found R3 lying in another resident's bed. there was blood all over the room and on the bed. V8 noticed a cut on R3's finger and notified the nurse.

On 11/1/21 at 12:45 PM V5 CNA stated: There was a crack to the top of R3's toilet tank lid. V5 was not sure when V5 noticed it. It was there

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S9999	Continued From page 9 before R3 cut R3's finger on 10/23/21. V5 didn't report the broken toilet lid to anyone. V5 didn't feel any sharp edges. V5 does not work all of the time and V5 thought someone else may have reported it. On 11/1/21 at 3:25 PM V1 Administrator stated: R3 has poor safety awareness and the facility believes R3 cut R3's finger on the top of the toilet tank lid that was cracked. On 11/1/21 at 2:52 PM V16 Nurse Practitioner stated: If the toilet lid was ceramic and cracked, it could have caused R3's cut. It could have been prevented if the CNA (V5) had reported the broken lid to V17 Maintenance. V17 would have prioritized replacing the lid to prevent any potential injury. "The CNA dropped the ball on that one." They could have taken another toilet lid from another room to replace the broken one until V17 was notified. (B)	S9999		