STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002182	A. BUILDING: _____ B. WING _____	C 11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINES AT COUNTRYSIDE	971 BODE ROAD ELGIN, IL 60120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Facility Reported Incident of September 27, 2021/IL138746 Facility Reported Incident of October 4, 2021/IL140046	S 000		
S9999	Final Observations Statement of Licensure Violations 330.720b) 330.4240a) Section 330.720 Admission and Discharge Policies b) No resident determined by professional evaluation to be in need of nursing care shall be admitted to or kept in a sheltered care facility. Neither shall any such resident be kept in a distinct part designated and classified for sheltered care. Section 330.4240 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 ensure residents were transferred in a safe manner to prevent injury, failed to make sure all residents admitted to the facility do not require staff's physical assistance during transfers, failed to make sure all residents admitted do not require nurse monitoring to	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 recognize the need for medical intervention, and failed to recognize and/or reassess a residents transfers need to determine if the resident is appropriate for shelter care. This applies to 2 of 3 residents (R101, R103) reviewed for safety in a sample of 3. As a result, R101 was injured during a transfer by staff and had to wait over 4 hours before medical attention was given to treat the pain and assess the extent of R101's injury that was associated with a fall. Findings include: R101's Physician's Order Sheet shows R101 was admitted to the facility on 1/2/16 with diagnoses including Dementia, Depression and Diabetes Mellitus Type II. R101's Incident Report dated 9/27/21 states, "(R101) was walking from the bathroom upon transferring (R101's) leg gave out and was assisted to the ground. At first no apparent injury, but an hour later she verbalized she was in pain. Then looking at her right leg it was swollen and looked displaced. Nurse notified, x-ray ordered and continued to monitor." On 11/5/21 at 9:50 AM, V1 (Executive Director of Nursing) stated, "R101 was a high fall risk. She could walk but I am not surprised she would do this too. They don't want her to walk now- she is a huge fall risk. At first when this happened her son did not want her to go to the hospital so we tried to do the x-ray here and everything but then it was just too bad and we had to send her out. The ortho doctor said he had to do the surgery because her muscle tone was just too good."	S9999		

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S9999	Continued From page 2	S9999		

On 11/5/21 at 10:10 AM V4(CNA) states, "(R101) was sitting on the toilet and I put the walker in front of her and I was going to have her stand up so I could pull up her brief- she usually walks with a walker for short distances. I had just done it with her a few days before. I got her up and then realized someone moved the chair so it was further away than I thought. She started turning and sitting down and the chair was not there so I eased her very gently to the ground. It was very soft and gentle. I yelled for help and 2 of my coworkers helped me put her back in the chair. I'm not sure if V3, Licensed Practical Nurse (LPN) assessed her or not. We got her into her soft reclining chair on wheels and about one hour later she was moving around a lot in her chair and saying her right leg really hurt. We looked at her leg and we could tell her leg was out of alignment. She is normally a one person assist for transfers. Her son didn't want to send her out to the hospital so we called the X-ray to come. V8 (CNA) was in charge and it was about 3-4 hours later that we actually sent her to the hospital because (V8) said it just looked too bad and she needed to go."

On 11/5/21 at 11:33 AM V3 stated, "She was in the first bathroom next to the dining room. I was at the desk but I had my head down writing something. I heard V4 yelling for help. V4 had been assisting her in the bathroom and she started going down. I ran over there quick and basically R101 was sitting on V4's lap. They were both in a squatting position. So I told (V4) to just lower (R101) to the floor because I was concerned about the safety of both of them. (V4) set (R101) down on the floor on her bottom. Then (V4) and I lifted (R101) into the chair while another staff member held the chair. I asked (R101) if she had any pain and we put her next to the nurse's station so I could watch her. I called

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S9999	Continued From page 3 the doctor and he ordered an x-ray and I called for that but then my shift ended about 9:00 PM so I left. I don't know what happened after that." On 11/5/21 at 1:00 PM V8 (CNA) stated, "I am in nursing school. We do not have a nurse there 24 hours a day. I kept checking on her and I finally called (V1- Executive Nursing Director) and told her that (R101) needs to go out. I was there when x-ray came and when we moved her to set her up for the x-ray (R101) was in a lot of pain. Right before x-ray came I looked at her and her right knee was bulging to the right. There was no redness, no bruising but maybe a little swelling. Her leg was not in alignment and she was in pain. I knew I needed to call (V1). I called her son and he agreed to send her out and then I called the private ambulance. I was there when they picked her up. I was probably there until about 1:00 AM." R101's Progress Notes dated 9/28/21 state, "(R101) was getting ready for bed with CNA. CNA claimed she was transferring to the chair when (R101) lost balance and was eased down to the ground. She was then assisted into soft reclining chair with wheels with 3 people. About half hour later resident began to complain of pain., Tylenol given and son notified. Requested to be sent out. (R101) was taken to (Local) Hospital. Fractured femur and will be having surgery on 9/29/21 at 4:00 PM." R101's X-ray Report dated 9/28/21 states, "Fracture of the mid-shaft right femur markedly overriding in distal segment anteriorly displaced." R101's X-ray Report dated 11/2/21 (Follow-up X-ray) states, "Spiral fracture distal right femur junction of middle and distal third with	S9999		

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S9999	Continued From page 4 transfixation with an intramedullary rod and locking screws with total knee arthroplasty noted." R101's Nurse's Progress Note (Monthly Summary) dated August 2021 shows that R101 requires maximum assist and 2 assist for transfers. R101's September Progress Note shows that R101 requires maximum assist for transfers. R101's Fall Prevention Plan dated 4/21/21 states, "Moderate fall risk as resident no longer can ambulate. Self propels in wheelchair and may slide out of chair at times. Family aware of risk. " On 11/5/21 at 10:35 AM V6 and V7 (CNAs) assisted R101 to the toilet. With one CNA on each side of her they lifted R101 by holding her under her arms and by the back of her pants. R101 was bearing some weight on the floor but did not straighten her legs completely. V6 and V7 then pulled (R101's) pants down, pivoted her and sat her down on the toilet. V6 and V7 did not use a gait belt to assist with R101's transfer. On 11/5/21 at 11:15 AM V5 (Home Health Physical Therapist) stated, "They don't use gait belts in this type of facility. As a PT I advocate for the use of gait belts but it is their policy. They don't use them in these types of facilities. I am currently working on sit to stand transfers with her in therapy. She uses the grab bar and is able to pull herself up. I don't think she will ever be able to safely return to a one person transfer. Her legs buckle unexpectedly. It has happened with me multiple times. She locks her knees and she just goes down. I could see how even lowering her to the ground, if her foot got caught underneath her, she could sustain a spiral fracture."	S9999		

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S9999	Continued From page 5 On 11/5/21 at 1:20 PM R102 was transferred from her soft reclining chair with wheels to the toilet with the assist of V9, V10 and V11 (CNAs). V9 and V10 lifted R102 by holding her under her arms and V11 pulled down R102's pants and brief. R102 had her feet on the floor but was not bearing all her weight so R102 appeared to be hanging from her arms. V9 and V10 then turned R102 and placed her on the toilet. On 11/5/21 at 1:25 PM V9 stated, "Sometimes we don't use a gait belt when we have 3 people. If we have enough people then we are okay. We use a gait belt when we have 1 person that can walk with a walker and then we hold on to the belt. Like when they can stand and walk with the walker. " On 11/5/21 at 12:56 PM V1 stated, "We don't use gait belts. We haven't in 13 years and no one has ever said a word about it." The facility's undated Transfer Policy states, "Safe transfer techniques can help protect the person and you from injury and falls." This same policy also states, "At times we may need to use devices such as gait belts." 2. R103's Incident Report dated 10/4/21 states, "CNA was walking resident on thin carpet in her wheelchair when resident fell forward out of the chair. (R103) landed on her right side including the right side of her head. Sustained 1 cm laceration above right eye. First aid given and ice applied with minimal bleeding. Bleeding stopped after 4 x 4 applied. Son notified and EMS called to transport to (Local) hospital for evaluation." R103's Progress Note dated 10/4/21 states, "Resident was being wheeled in her wheelchair by CNA when resident fell out of chair after foot	S9999		

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S9999	Continued From page 6	S9999		

hit the carpet. Fell onto right side including right side of head. Sustained 1 cm laceration to above right eye. First aid and ice applied. No complaints of pain. Able to move all extremities. No change in mental status. Son notified and EMS called to transport to (Local) Hospital ER for eval. Received 3 sutures to forehead. CT to head negative. Return to (facility) via ambulance. "

On 11/5/21 at 1:00 PM R103 was lying in bed, covered with a blanket. R103 had a small red scar to the right outer eyebrow. The area was healed. R103 is not interviewable.

On 11/5/21 at 2:30 PM V2 (Executive Director) stated, "I was at the nurse's station and the CNA was wheeling her down the East Hall. I came around the corner and (R103) was on the floor in front of the wheelchair. The CNA had left to find help and someone else was standing there by her. She was not able to propel herself at the time. She did not have leg rests on the wheelchair. I have always instructed them to put a hand on the resident's shoulder as they are pushing them. Most of the residents do have leg rests but at one time (R103) was propelling herself."

On 11/5/21 at 3:45 PM V12 (CNA) stated, "I was wheeling her and she put her right foot down and flipped out of the wheelchair head first. She was usually able to hold her feet up but she usually has leg rests on her chair and that day she did not have them on. When she fell I went and got help right away. (V2) came to help me/(R103). (R103) was sent to the hospital."

On 11/5/21 at 11:15 AM V5 (Home Health Physical Therapist) stated, "I used to work with R103. She used to propel her own chair with her

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S9999	Continued From page 7 feet. She used to be so much better. I typically don't recommend foot rests for residents that can propel themselves. If they are not able to lift their feet and hold them up for a sustained period of time then I would recommend foot rests." R103's Nurse's Progress Notes dated for August, September and October 2021 shows that R103 requires maximum assist for locomotion. The facility Census Report provided by the facility on 11/5/21 states, "PLEASE MAKE SURE ALL WHEELCHAIRS HAVE THEIR LEG RESTS ON." (A)	S9999		