Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001739	A. BUILDING: ______ B. WING ______	C 01/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN NURSING HOME	1507 7TH STREET LINCOLN, IL 62656

(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 Complaint 2220167/IL142166	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b)5) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies 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. 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	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

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.

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 300.3240 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 prevent a resident from sustaining a dislocated shoulder and failed to thoroughly investigate an injury of unknown origin to determine the cause for one resident

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(R1) reviewed for accidents. This failure resulted in R1 sustaining a right anterior dislocation of the humeral head (shoulder) which required hospitalization.

Findings include:

A Prevention of Abuse Policy dated 2/6/17 documents, "The facility will consider factors indicating possible abuse, neglect, and/or exploitation of residents, including, but not limited to, the following possible indicators: Injuries of unknown source-An injury should be classified as an 'injury of unknown source' when both of the following conditions are met: The source of the injury was not observed by any person or the source of the injury could not be explained by the resident and The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incident of injuries over time"

An Investigation Process policy (undated) documents, "All accidents require a thorough investigation in an attempt to determine what occurred and to make changes as needed, to prevent reoccurrence. A thorough investigation is a systematic (Consistent and ordered) collection of information that describes and explains an event or a series of events. The investigation seeks to determine if and how abuse, neglect, negligent treatment, exploitation, or misappropriation of resident property occurred." This policy further states, " If the first phase of investigation allows the investigator to answer and document 'who, what, when, where, why, and how' and, therefore, establish a reasonable cause or know(n) source of the incident or injury within

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24 hours of the incident or injury, an extended investigation is not required. However, if the investigator is unable to establish reasonable or known source, further investigation is required." In addition, this policy states, "Further investigation is required if the first phase of the facility investigation did not establish reasonable cause of source of allegation or injury within 24 hours. The following elements may be included: a. Interviews of expanded sample of witnesses, historians b. Expand the time frame surrounding the incident c. Obtain related clinical professional expertise e. If suspected perpetrator is staff, interview other assigned residents."

An Occurrence and Event policy dated 5/14/13 states, "It is policy of (This facility) to provide a safe environment that strives to eliminate hazards and to provide adequate care, supervision and assistive devices to prevent accidents. To this end, all occurrence or events regarding a resident or visitor injury, including unexplained bruises or abrasions will be investigated." This policy also states, "Investigate any occurrence/event, by reviewing the chart, and interviewing care givers and staff who may have witnessed the event or may have assessed or spoken with the resident, family or other witnesses prior to or after the event," and "The Director of Nursing Services/Administrator of Clinical Services or his/her designee will evaluate the reports for thoroughness. Any additional investigation will be conducted to determine possible causes. A summary of causes/trends concerns will be recorded."

A Mayo Clinic informational sheet called Dislocation: First Aid (undated) documents that, "A dislocation is an injury in which the ends of your bones are forced from their normal

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positions. The cause is usually trauma resulting from a fall, an auto accident, or a collision during contact or high-speed sports."

A standing mechanical lift manufacturers booklet (undated) states, "Individuals that use the standing patient sling must be able to support the majority of their own weight, otherwise injury may occur."

R1's Minimum Data Set (MDS) assessment dated 10/5/21 documents that at that time R1 was unable to complete a brief interview for mental status, however, staff assessment of R1's cognitive skills for daily decision making indicate R1 makes poor decisions and requires cueing and supervision. This MDS assessment also documents R1 requires extensive assistance of two people for bed mobility, transfers, dressing, eating, toilet use, and personal hygiene. This assessment also documents R1 did not walk during the assessment period.

R1's Functional Abilities OBRA Comprehensive and Quarterly assessment dated 10/5/21 documents that R1's ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, with no back support; R1's ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed; and ability to get on and off a toilet or commode is dependent on staff to provide all of the effort meaning R1 does none of the effort to complete the activity. This assessment also documents R1's ability to mobilize using a wheelchair requires staff to lift or hold R1's trunk or limbs and provides more than half of the effort.

R1's current Care Plan documents that R1 is at risk for ADL (Activities of Daily Living) Self-care

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deficiency related to: Dementia and requires extensive assist of two staff with use of the standing mechanical lift as needed for all transfers. R1's Care Plan also states, "(R1) is at risk for falls (related to) Unaware of safety needs, Wandering, and self-transferring to the floor, history of falls, unsteadiness on feet, muscle weakness, narcotic usage."

R1's Physical Therapy progress and discharge notes dated 10/17/21 documents R1 was evaluated for safe use of the standing mechanical lift at that time. These notes document the evaluation for use of the lift was conducted between 10/8/21 and 10/17/21 during which time R1 was dependent on staff for 90-95% (percent) of the effort in the transfer process during the initial therapy session and remained dependent on staff showing no improvement by the time R1 was discharged from therapy 10/17/21.

R1's medical record documents a standing mechanical lift safety screening was conducted by the therapy department on 9/23/21 at which time the therapist did not visually evaluate R1's ability to safely use the mechanical lift, but instead, the therapist asked the opinion of a Certified Nurse Aide (CNA) who reported there were no changes in R1's transfer abilities.

On 1/11/22 at 1:00p.m. V4 (Therapy Director) stated that when R1 was provided therapy to ensure standing mechanical lift safety 10/8/21 to 10/18/21, R1 was not cooperative during therapy sessions and, therefore, was discontinued from therapy treatments. V4 stated that since R1 was already using the standing mechanical lift, therapy did not recommend any changes such as down grading R1 to a full body mechanical lift, despite R1's requirement for staff to provide

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S9999	Continued From page 6 90-95% of the effort. V4 stated that R1 has received Physical Therapy screenings for mechanical lift safety but those screenings may just include asking CNA staff how a resident is doing with their transfers instead of observing a resident during a transfer. V4 verified that R1's last screening on 9/23/21 did not include the therapist observing R1 for safety during a transfer, but instead, the therapist asked CNA staff for their opinion on how R1 was doing. On 1/11/22 at 9:55a.m. R1 was seated in a specialized high-backed wheelchair in the activity room of the secured memory care unit. R1 did not speak when spoken to and was noted to keep both her right and left arms resting in her lap. There was no visible right shoulder deformity through R1's clothing. At approximately 11:00a.m. V11 (R1's Power of Attorney/POA) arrived at the facility and pushed R1's wheelchair into a family visitation area. At 12:00p.m., V11 stated that the facility has not provided her with answers on how R1's shoulder dislocation occurred. V11 stated that she suspects R1 fell or was injured during a mechanical lift transfer. V11 stated that R1 has had previous falls at the facility in which she developed bruising and swelling to her face. V11 stated that she was at the facility the day R1's shoulder dislocation was found. V11 stated originally the facility thought R1's shoulder and arm were just swollen from arthritis. V11 stated that R1 had an X-ray which showed R1 had a dislocated right shoulder. V11 stated that the facility thought R1's right shoulder dislocation could have occurred during a standing mechanical lift transfer, but they are not sure. V11 stated that the facility stated the dislocation could also just be the result of R1's advanced age. V11 stated that on 12/28/21 R1 was sent to the hospital where V11 was told that R1's right	S9999		

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S9999	Continued From page 7 shoulder dislocation could only have occurred as a result of trauma. V11 stated that the hospital Physician said R1's injury could have occurred up to three days before being transferred to the hospital. R1's Hospital Physician's Clinical Report dated 12/28/21 states, "Chief Complaint: Injury to right shoulder. The injury happened about two days ago. Occurred at a (Facility). Unclear cause but (V11) states the nursing home staff suspect injury might have occurred while using a (mechanical lift) to transfer (R1)." In addition, this clinical report states, "There is no known history of shoulder dislocations." R1's hospital X-ray report dated 12/28/21 states, " Right Shoulder: There is anterior and inferior dislocation of the right humeral head with respect to the right glenoid." On 1/11/22 at 4:36p.m. V10 (R1's Orthopedic Physician) stated R1 has a dislocated right shoulder which could not be put back into place while R1 was in the hospital. V10 stated that he cannot give a definite cause or time frame for R1's right shoulder dislocation. V10 stated that R1 does not have a history of shoulder dislocations which would predispose R1 to another dislocation; and V10 stated that R1's shoulder dislocation would not have occurred spontaneously, meaning without a cause. V10 stated, in his opinion, R1's injury could have occurred up to three days before the facility noticed it. On 1/11/22 at 9:55a.m. V5 (Memory Unit Manager) stated that V11 noticed some swelling to R1's right hand while she was visiting with R1 on 12/27/21. V5 stated that V11 thought the	S9999		

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S9999	Continued From page 8 swelling could be from R1's arm hanging down along the side of R1's wheelchair. V5 stated that soon after finding the swelling, V6 (CNA) and V7 (CNA) were providing R1 with toileting when they noticed R1's arm looked funny. V5 stated V6 and V7 had R1's nurse assess R1's arm at which time the nurse called R1's Physician to ask for R1 to have an x-ray to R1's arm. V5 stated that the X-ray showed that R1's right shoulder was dislocated at which time R1 was sent to the hospital. V5 stated that she helped V2 (Director of Nurses) investigate the cause of R1's dislocation. V5 stated that she and V2 determined that R1's injury must have occurred between 2:00a.m. and 9:00a.m. on 12/27/21. V5 stated she and V2 decided that R1's injury most likely occurred during a standing mechanical lift transfer. V5 stated that R1 has no trunk control and requires staff to physically lift her into a sitting position. V5 stated that because of R1's lack of trunk control, R1 naturally leans back with R1's full weight. V5 stated that in preparation for the standing mechanical lift transfer, CNA staff must push on R1's back while they attach the transfer strap which fits around R1's waist and is also attached to the standing mechanical lift. V5 stated that while CNA staff are hooking R1's strap up to the lift, they must push on her back because R1 clinches her arms to her side and leans backward. V5 stated she and V2 determined R1's shoulder dislocation occurred as a result of staff pushing on R1's back while hooking R1 up to the standing mechanical lift. V5 also stated that R1 does not always hold onto the safety grab bars on the lift. V5 stated she believes R1's right shoulder dislocation could have been avoided if staff had relayed to her that R1 has a lot of resistance when they place the mechanical lift sling or that R1 does not always hold onto the safety grab bars. V5 stated R1's dislocated shoulder could	S9999		

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S9999	Continued From page 9 have also been avoided if staff had reported that R1 was totally dependent on staff and the machine to lift her into an upright position. V5 stated that if staff had notified her of R1's transfer safety concerns, the facility could have changed how R1 is transferred from place to place before R1 sustained an injury. V5 stated that now R1 is a full body mechanical lift for transfers, meaning R1 does not need to assist in the transfer by sitting up, standing, or holding onto grab bars. On 1/11/22 at 10:22a.m. V6 stated that she was one of R1's CNAs on 12/26/21 during the 2:00a.m. to 2:00p.m. shift. V6 stated that R1 is cognitively impaired. V6 stated that around 4:45a.m. on 12/26/21, V6 and V7 were preparing to transfer R1 from the bed to the wheelchair using the standing mechanical lift. V6 stated that at the time of R1's transfer, she did not have any swelling to her right hand. V6 stated that R1 cannot sit up by herself and requires total assist from two staff to sit up. V6 stated, "You can't sit her up yourself because she is too stiff. It's hard to get (R1) to bend to a sitting up position. " V6 stated that once R1's safety strap was attached to the lift, V7 used the controls to lift R1 from the bed then transfer R1 to the wheelchair. V6 stated that R1 did not hold onto the safety grips during the transfer. V6 stated she did not see anything unusual occur during the transfer, and R1 did not express any discomfort during the transfer. V6 stated that sometime around 9:30a.m. to 9:40a.m. that same morning, V6 and V7 took R1 to the bathroom using the standing mechanical lift. V6 stated she noticed that R1's fingers were swollen. V6 stated she looked under R1's shirt and saw that R1 had developed a horizontal bruise to the top of her right arm. V6 stated that R1 did not express any pain during her initial mechanical lift transfer that morning. V6 stated	S9999		

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that she did not believe any injuries occurred to R1 during the mechanical lift transfer.

On 1/11/22 at 9:53a.m. V7 stated that she was R1's CNA on 12/27/21 at approximately 4:45a.m. when she and V6 transferred R1 from the bed to the wheelchair using the standing mechanical lift. V7 stated that R1 requires total assistance to sit up at the side of the bed. V7 stated that once R1 is sitting up on the side of the bed, staff must hold onto R1 or she will fall backwards. V7 stated that when staff tries to sit R1 up, R1 tries to lean away. V7 stated that during R1's transfer, both V6 and V7 had to push on R1's back to hold R1 up and push on R1's back to attach the safety strap to the mechanical lift. V7 stated that she and V6 placed R1's hands on the safety grab bars but R1 wouldn't hold on. V7 stated that R1 was unable to bear weight and stand herself up. V7 stated that R1 holds her arms tightly to her body so staff must try to raise her arms to apply the mechanical lift safety strap. V7 stated after V6 and V7 transferred R1 to the wheelchair, it was not until around 9:30a.m. when V6 noticed there was something wrong with R1's right arm. V7 stated, "We have been trying to tell them (the facility) for a long time that (R1) is not appropriate for the (standing mechanical lift)." V7 stated that she had also told therapy she did not think R1 was appropriate for the standing mechanical lift. V7 stated that it is the therapy department who evaluates residents for the use of mechanical lifts. V7 stated, "It was a while back that we told them that, but therapy still kept her as a (standing mechanical lift)."

R1's injury investigation dated 12/31/21 documents, "An investigation on root cause of the dislocation was conducted including interviewing of staff who care for (R1) on date of 12/27(/21)

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S9999	Continued From page 11 and previous two days. Per plan of care, (R1) transfers with the assist of a (standing mechanical lift) and two staff members. On the morning of 12/27/21, (R1) was transferred from bed via the (standing mechanical lift) with the assistance of two CNAs." This investigation gives as its conclusion, "All staff members who cared for (R1) during the time period being investigated stated that at no time was the resident lifted or transferred outside the normal protocol of the (standing mechanical lift) with two assists. Given the time that the injury was noted, it is possible that the dislocation occurred during the early morning transfer. However, there is not conclusive evidence since the transfer was done appropriately and there is no indication by (R1) of any pain or discomfort at that time. Similarly, all previous transfers were also performed per the plan of care appropriately. Given the residents history of shoulder pain (Potentially indicating previous injury) and her advanced age, there may have been a pre-disposition for the shoulder dislocation. The investigation concludes that the injury did not occur due to abuse or inappropriate care of the resident." This same investigation includes R1's X-ray results and hospital after care instructions but does not include the hospital Physician's progress notes or V10's (R1's Orthopedic Specialist) progress notes. In addition, this investigation includes interviews with only seven staff members, (V6, V7, V9 (CNA), V12 (CNA), V13 (CNA), V14 (CNA), V15 (CNA), who cared for R1 in the three days before her injury was discovered. None of these interviews included R1's nurses or the remaining CNAs who cared for R1 between 12/24/21 to 12/27/21, which includes the three days which proceeded when the facility found R1's shoulder dislocation. This investigation did not include any further investigation was conducted to determine	S9999		

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the cause of R1's injury despite being unable to establish reasonable or known source as is required by the facility's Investigation Process policy. This investigation also did not document an investigation into other potential causes of R1's injury, such as an unreported fall, after concluding R1's mechanical lift transfer was done appropriately.

V12 (CNA) stated during her interview that she was R1's CNA from 10:00p.m. 12/25/21 to 6:00a.m. 12/26/21. V12 stated that when she "Turned (R1) back and forth to change her (incontinence) pad, (R1) said '(Ouch).' I assumed that her discomfort was from her lying on her arm prior to my arrival."

During V9's interview with V2 regarding R1's injury of unknown origin, V9 stated that during dinner on 12/26/21 at around 5:15p.m., R1 became ill and vomited. V9 also stated during this interview that V8 (CNA) took R1 to her room and transferred R1 to bed. On 1/11/22 at 3:44p.m. V9 verified the contents of his interview.

On 1/11/22 at 3:36p.m. V8 (CNA) stated that he was one of R1's CNAs on 12/26/21 during the 2:00p.m. to 10:00p.m. shift. V8 stated that after R1 became sick and vomited during dinner that evening around 5:30p.m., V8 took R1 back to her bedroom and transferred R1 to the bed using the standing mechanical lift. V8 stated, "I will admit, I transferred (R1) myself without another person." V8 stated, " For the last few times I've worked (with R1), she has clamped her right arm to her side. She held both arms to her side. She is normally like that and kind of stubborn."

A Team Schedule dated 12/24/21 through 12/27/21, three days prior to discovering R1's

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001739	A. BUILDING: ____ B. WING ____	C 01/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN NURSING HOME	1507 7TH STREET LINCOLN, IL 62656

(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
S9999	Continued From page 13 injury, documents that a total of 13 CNAs and five nurses cared for R1 between 12/24/21 to 12/27/21 when R1's injury was discovered. (B)	S9999		