STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012512	A. BUILDING: _____ B. WING _____	C 01/19/2022

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S 000	Initial Comments Facility Reported Incident of January 4, 2022/IL142471	S 000		
S9999	Final Observations Statement of Licensure Violations: 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 and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the 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	S9999	**Attachment A** Statement of Licensure Violations	

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S9999	Continued From page 1 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. 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. 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. These requirements are not met as evidenced by: Based on interview and record review the facility failed to provide the required assistance during resident transfer for 2 (R3, R4) of 3 residents reviewed for accidents in a sample of 6. This failure resulted in R3 sustaining a fracture at the distal shaft of the left tibia and fibula. Findings include: 1. R3's Resident Profile Sheet documents admission to the facility on 06/03/13, a re-admission date of 11/18/19, and a discharge	S9999		

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S9999	Continued From page 2 date of 01/11/22. R3's Medical Diagnoses Sheet documents the following in part - Chronic Obstructive Pulmonary Disease (COPD), Dementia, Anxiety, Personal history of Covid-19, Age-related osteoporosis without current pathological fracture, Fracture of Left Lower Leg - closed fracture with routine healing, Muscle wasting and atrophy, Dependence on wheelchair, and Protein-calorie malnutrition. R3's most recent quarterly MDS (Minimum Data Set) dated 12/13/21 documents the following: R3 is moderately cognitively impaired with a BIMS (Brief Interview for Mental Status) score of 8. R3 was assessed as requiring extensive 2+ person physical assist for transfers with the use of a mechanical lift. R3's Care Plan dated 11/18/19 with an update on 01/04/22, documents the following in part - "Focus: I require assistance with my ADLs (activities of daily living) ...I use my Geri chair as my primary mode of locomotion which I require assistance with ... Interventions/Tasks: Please use a mechanical lift for all transfers with extensive assist of 2 for resident and staff safety ...Focus: I am receiving hospice services through Residential Hospice. Goal: I will receive safe and compassionate care ...Interventions/Tasks: Notify Residential Hospice of any change in status, falls, or incidents. Focus: I am at risk for falls related to impaired cognition, forgetfulness, abnormal posture, non-ambulatory, dependence on Geri-chair, right lower extremity and left lower extremity contractures, mechanical lift x 2 assist transfers ...On 01/04/22, I sustained a left lower extremity fracture due to improper staff transfer. The staff member was suspended for pending investigation, immediate staff on duty were educated to read care cards for proper transfer	S9999		

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S9999	Continued From page 3 status and educated on policies for transfers with gait belt and policies on mechanical lift transfers. I received orders to apply splint to left lower extremity splint and elevate as tolerate related to edema, check pedal pulses left lower extremity every shift, Morphine Sulfate every 3 hours for pain, Acetaminophen-Codeine one tablet every 6 hours. Goal: I will remain free from fall or injury through next review. Interventions/Tasks: Please use a gait belt when assisting me with transfers ...See previous fall interventions ..." R3's Care Card documents the following in part - " ...I need +2 assist to transfer. I use a mechanical lift ..." ..."I need to use the following devices: B (bilateral) fixed leg rest on w/c (wheelchair); Right side lateral support in w/c; B leg rests with blue drop stop footrest; Pt (patient) to wear shoes every day; mechanical lift for transfers ..." R3's progress note dated 1/4/2022 at 2:30 PM documents the following in part - Incident Note - This nurse (V4 - Licensed Practical Nurse - LPN) called to resident room by CNA (V18) r/t (related to) CNA had assisted resident from Geri-chair to bed. CNA stated "I went to change her depend and lifted resident from Geri-chair to bed with my arms under the resident underarms to set her down on the bed. I heard a noise, and her leg was against my leg and the bed. So, I set her in bed and then I noticed how she was holding her left leg. I then told the nurse." R3's same progress note further documents V4 reported this incident to V2 (Director of Nursing - DON) and V9 (LPN/MDS - Minimum Data Set). V2 and V9 performed assessment of resident left leg and instructed this nurse to notify hospice along with family. "Resident in bed at this time	S9999		

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S9999	Continued From page 4 laying on right side ... Recommendations: Order given to get x-ray 2 views of left tibia/fibula along with ankle dx (diagnosis) acute pain from Hospice nurse when called." R3's x-ray report dated 01/04/22 at 6:50 PM documents the following - Procedure: Left tibia and fibula, two views ...Impression: Acute non-displaced comminuted fracture at the distal shaft of the tibia and the fibula. R3's facility Incident/Injury Report Investigation dated 01/04/22 at 2:30 PM by V4 (LPN) documents the following in part - Resident: R3. Incident Location: Resident's Room. Incident/Nursing Description: This nurse called to resident room by V18 (CNA) r/t (related to) V18 had assisted resident from Geri-chair to bed. V18 stated she went to change R3's incontinence brief and lifted R3 from Geri-chair to bed with her arms under resident's underarms to sit her down on the bed. V18 reported hearing a noise and R3's leg was against V18's leg and the bed. V18 sat R3 down in bed and noticed R3was holding her left leg. V18 then told V4 who then reported the incident to V2 (DON) and V9 (LPN/MDS). V2 and V9 performed R3's assessment of left leg and instructed V4 to notify hospice along with family. A handwritten document provided as part of the facility incident investigation dated 01/07/22 by V9, documents that V18 acknowledged the purpose of care cards, mechanical lift pad under R3 in the Geri-chair, and knowing R3 was a x2 assist with mechanical lift for all transfers since employment. In this document, V18 is quoted as saying, "I've never mechanical lifted (R3). She's lighter than my kid, doesn't weight much. It's easier and quicker to use my body. I just tell her	S9999		

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S9999	Continued From page 5 to put her arms around me." V9 documents the conversation occurred between 4:00 PM to 4:30 PM in R3's room. On 01/14/22 at 10:13 AM, V9 (LPN/MDS) stated that on 01/04/22, V18 reported the incident between V18 and R3 to V9 and V2 (DON). V9 stated she and V2 went to R3's room to assess her and observed R3's care card at the doorway, and mechanical lift pad in place in her Geri-chair beside the bed. V9 stated when she interviewed V18 after the incident, V18 confirmed she was transferring R3 from the Geri-chair to the bed to change her. V9 stated R3 was obviously in pain and the inner part of her left leg and ankle had already began to show discoloration. V9 confirmed she told V18 that R3 required a mechanical lift with 2+ person transfer. V9 stated, V18's response was that she knew that, but she never used the mechanical lift because it was easier for V18 to transfer R3 without because she did not weight much. V9 stated V18 was immediately taken off the floor and sent home pending the investigation that had been initiated. On 01/14/22 at 10:20 AM, V3 (Regional Director of Clinical Operations) stated she was aware of R3's improper transfer incident involving V18. V3 stated that unfortunately, the facility made the decision that V18 would likely continue to provide care in the same manner given her statements during the investigative process and providing education would not change future outcomes concerning resident care. Therefore, the decision was made to terminate V18's employment at the facility. On 01/14/22 at 10:46 AM, V6 and V8 (CNAs) both stated resident care cards are placed outside resident doorways to provide a quick	S9999		

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S9999	Continued From page 6 overview of the care and assistance required for each resident. V6 and V8 confirmed they received education and training on resident transfer, gait belt use, and mechanical lift procedures on 01/04/22. On 01/14/22 at 2:43 PM, V18 (CNA) was interviewed via phone conversation related to the incident on 01/04/22 involving herself and R3. V18 stated she went to R3's room to change her. V18 stated she turned R3's Geri-chair around and positioned it like she always did. V18 lifted R3 up stating R3 was never difficult to lift - that R3 usually just grabs on to her shoulders and they have no issues, which is what occurred on 01/04/22. V18 continued to describe turning R3 during transfer like she always does and at that point, V18 didn't know if it was how R3's leg was pressed up against her own leg and then against the bed, but V18 heard a noise, sat R3 down in bed, and went to get the nurse. V18 confirmed she was aware R3 was assessed as a two-person mechanical lift assist, but stated she's just always done it by herself with no problems because R3 doesn't weigh anything.V18 stated "She's as light as my kids." The nurse assessed her and V18 understood R3 had a fracture. V18 stated she felt terrible and was sorry this ever happened. On 01/18/22 at 1:20 PM, V21 (CNA) stated she knows the residents' assist requirements, what they can and can't do, but stated there are reminder cards on each door so you can check if you need to. She absolutely does not attempt to lift or transfer a resident by herself if they are 2-assist. V21 stated she was aware of the incident in which R3 sustained a fracture and confirmed all CNAs received education and training, herself included, after the incident on	S9999		

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S9999	Continued From page 7 01/04/22. R3's Certificate of Death Worksheet documents the following in part - Date of Death: 01/11/22. Cause of Death: a. Cerebral Atherosclerosis. Approximate Interval Between Onset and Death: Unknown. Manner of Death: Natural. Time of Death: 7:45 AM. A facility policy titled, "Mechanical Lift" dated October 2017 documents the following in part - "Policy: The mechanical lift may be used to lift and move a resident with limited ability during transfer while providing safety and security for residents and nursing personnel. Responsibility: All nursing personnel. Equipment: Mechanical lift, sling, chair or wheelchair, if needed ..." A facility educational handout titled, "Transfer Program" documents the following in part - "Purpose of Transfer Program - Enable the resident to transfer safely ...Weight Bearing Status: Full weight bearing, partial weight bearing, toe touch, weight bearing as tolerated and non-weight bearing ...Transfer Guidelines: ...Follow specific orders as to the type of transfer to be performed ..." 2. R4's Face Sheet documents an admission to this facility on 04/16/16, with a re-admission date of 11/05/17. R4's Medical Diagnoses Sheet documents the following in part - COPD, Pulmonary fibrosis, dementia, anxiety, a-fib, dependence on wheelchair, muscle wasting and atrophy, need for assistance with personal care, lack of coordination, history of falls. R4's most recent quarterly MDS dated 09/15/21	S9999		

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S9999	Continued From page 8	S9999		

documents R4 is assessed as needing extensive 2+ personal physical assist during transfers. R4 was also assessed as being unable to conduct an interview to determine a BIMS score due to R4 being rarely/never understood.

R4's care card documents she requires a 2+ person assist with all transfers.

R4's Witnessed Fall Incident Report dated 12/03/21 at 4:10 PM documents in part - Incident/Nursing Description: Called to room by another nurse walking past resident's room ....entered room, resident was laying on her right side on CNA who was laying on her back on the floor. Both resident and CNA head adjacent from head of bed and feet outward toward foot of bed. Wheelchair was locked and at foot of bed ...resident was wearing gait belt and non-skid socks. Immediate Action Taken: Area assessed, no signs/symptoms of pain or discomfort ...2 cm (centimeter) line on right side of forehead with scant blood noted after resident was up in wheelchair ...Other Information: CNA was transferring elder from wheelchair to bed, resident's feet began sliding and resident was leaning towards CNA. CNA lowered resident and self gently to floor, CNA leaned back so that CNA and resident were laying flat on floor. Notes: CNA was transferring elder from wheelchair to bed when her feet slid, and she assisted her to the floor as she could not hold her up. After speaking with CNA, it was determined she used a gait belt and 1 assist during this transfer. Elder is a 2 assist transfer for this reason. Staff education provided again where to find transfer status and to follow the recommended transfer status for each resident.

On 01/18/22 at 10:00 AM, V17 (Assistant DON)

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S9999	Continued From page 9 stated that V20 (CNA) was involved in the improper transfer of R4 on 12/03/21 and would not further communicate with the facility after the incident. V17 stated she read the Summary of Incident to V20 over the phone on 12/06/21, then documented the incident on an Employee Disciplinary Form. V17 stated V20 refused to sign and did not return to the facility. A facility policy titled; "Falls Prevention Program" dated revised on 10/15/21 documents the following in part - "Fall Prevention Program Components: ... 1. Method to identify risk factors: b) Resident transfer assessment; c) History of falls; ...f) Discussion of individual circumstances ...Physical Capabilities: ...4. How to determine resident is at risk for falls: e) MDS - Codes the resident as type of assistance required and the amount of assistance required. Addresses standing/sitting balance, mobility, gait, vision and cognitive status ..." (A)	S9999		