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	IL6011688	A. BUILDING: _____ B. WING _____	C 07/19/2022

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S 000	Initial Comments Complaint Original Investigation #2225546/IL149049	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 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. 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 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 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. 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 the following: Based on interview and record review the facility failed to implement safe mechanical lift transfer measures, based on resident assessments, by ensuring two staff were present during the mechanical lift transfer for a resident with poor balance and severe limitation in range of motion, which affected one of three residents (R1) reviewed for falls in a sample of four. These failures resulted in R1 losing balance while sitting on the edge of the bed, following a mechanical lift transfer by one staff member, and falling to the ground sustaining an Intraparenchymal Hemorrhage. Findings include: A Food and Drug Administration (FDA) Patient	S9999		

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S9999	Continued From page 2 Lifts Safety Guide (undated) documents safety measures to employ while using a mechanical lift. This guide states, "A floor-based, full-body sling lift is featured throughout this guide; however, the information applies to all patient lifts," and "Most lifts require two or more caregivers to safely operate lift and handle patient." This guide uses visual aides to demonstrate lift safety and shows two care givers involved in patient transfers, one to operate the machine and a second person to assist the patient. A Safe Resident Handling Program policy dated 3/18/18 states, "Initial screening will be performed on all residents to assess transfer & ambulating status. Resident transfer status will be reviewed via care-plan time frame and on an as needed basis. If therapy recommends a change in transfer status the recommendations will be reviewed by a nurse manager prior to changing the status in the care plan." R1's Admission Record of diagnoses includes Dementia without Behavioral Disturbances, Cerebral Infarction, Heart Failure, Chronic Pain, Osteoarthritis, Arthropathy, Dysphagia, Cognitive Communication Deficit, Feeding Difficulties, Essential Tremor. R1's Minimum Data Set (MDS) assessment dated 2/01/22 documents R1 is severely cognitively impaired, requires extensive assistance for bed mobility, transfers, does not walk, and requires extensive assistance for locomotion in a wheelchair. This same MDS documents R1 is not steady and only able to stabilize with staff assistance during surface-to-surface transfers meaning transfers between bed and chair or wheelchair and has a functional limitation in range of motion to both	S9999		

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S9999	Continued From page 3 R1's upper extremities and one lower extremity. In addition, R1's MDS section GG Functional Abilities and Goals documents that during a lying to sitting on side of bed or chair/bed to chair transfer, R1 requires substantial/maximal assistance where the helper does more than half the effort and the helper lifts or holds R1's trunk or limbs and provides more than half the effort. R1's Morse Fall Scale assessment dated 1/31/22 documents R1 is at high risk for falling because R1 has a history of falls, is non-ambulatory with a mental status which indicates R1 overestimates or forgets the limits of R1's abilities to ambulate safely. R1's Physical Therapy (PT) Discharge Summary dated as signed 11/22/21 documents upon initiation of therapy, R1 had a therapy goal to improve R1's ability to move from a lying to sitting position and a sitting to lying position. This summary documents that at the time of discharge R1's ability to perform this task remained unchanged from baseline. This same PT discharge summary documents that, at baseline, R1 leaned 30 degrees to the right from a neutral alignment with a 40-degree lateral flexion to the left and with a 30-degree rotation of R1's upper body to the right and with R1's body flexed forward at an angle of 30 degrees. R1's PT goal for leaning to the left with rotation to the right and leaning forward was to improve R1's cervical spine side bending to only 15 degrees from a neutral alignment. This summary documents that R1 was able to meet this goal of leaning only 15% on 11/9/21. R1's PT discharge summary also documents R1's sitting balance was considered "fair -" with the goal of improving R1's sitting balance to "fair +" in order to improve R1's participation in using the sit/stand mechanical lift	S9999		

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transfer device. At the time of discharge from physical therapy, R1 was unable to meet R1's sitting balance goal and remained unchanged from her baseline. R1's PT goal of improvement in dynamic sitting balance to "Fair "in order to improve R1's stability during Activities of Daily Living (ADL) and sit/stand mechanical lift transfers was unmet with R1's ability remaining unchanged from baseline. At the time of R1's discharge from PT, R1's sitting balance was fair for static sitting balance and poor for dynamic balance.

On 7/19/22 at 10:40a.m. V7 (Therapy Manager) stated that R1 was receiving physical and occupational therapy from 10/25/21 to 11/17/21. V7 stated that R1 was discharged after less than a month because she had reached her maximum potential. V7 stated that R1's maximum potential was the same as her baseline from the start of therapy. V7 stated at the time of therapy discharge R1 required a total staff assistance with the use of a standing mechanical lift. V7 stated R1 was not expected to make any additional improvements. V7 stated the Therapy Department did not perform any additional evaluations to R1 after R1's discharge from therapy 11/17/22.

R1's current care plan documents that as of 10/25/21 R1 was at risk for falls related to R1's age, use of medications that may cause dizziness, weakness and history of a fall. R1's fall risk care plan goal was to minimize R1's risk of injury related to falls. R1's care plan fall prevention interventions included: the use of a "Mechanical stander for all transfers" on an as needed basis (PRN) which was initiated on 11/2/21 and discontinued 2/15/21. On 2/15/22 the intervention of "Mechanical sling lift with 2 (two)

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assist for all transfers," PRN was added to the care plan as a new fall prevention measure. R1's care plan for ADL Self Care Performance Deficit dated 10/26/21 documents R1's ADL self-care deficit is related to R1's weakness, confusion, low back pain, sedentary behavior, incontinence, limited range of motion to bilateral upper extremities and left lower extremity. This ADL care plan documents as interventions dated 10/26/21, "May use mechanical sling lift with 2 assist with increased difficulty bearing weight," and "(R1) to transfer with (standing mechanical lift) x 1 (one) assist," also dated 10/26/21. This ADL care plan does not show R1's ADL interventions were updated on 2/15/22 when R1's fall risk care plan interventions were reviewed and updated.

R1's progress note dated 3/16/22 at 12:54p.m. and entered by V3 (Registered Nurse) documents that on that date, "Staff assisting resident to bed via mechanical stander x 1 staff. When removing mechanical stander away from resident/bed, resident fell to floor. Resident hit her head when falling to floor. Laceration noted to (right) temporal portion of head. Applied pressure with towels. Unable to stop bleeding from area." Further, this nursing progress note documents R1 was sent emergently to the hospital for evaluation and treatment. R1's progress note dated 3/16/22 at 5:34p.m. states, "IDT (Interdisciplinary Team) Fall Team meeting held to discuss resident's recent fall. Root cause of fall: Decline in (R1's) functional ability and was unable to maintain sitting position on edge of bed. Intervention: (R1) was sent to ER (emergency room) for eval and treat. Ongoing intervention: Transfer (R1) with mechanical stander and 2 assist." R1's progress note entered at 6:45p.m. documents R1 returned to the facility with sutures in place. R1's progress

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note entered at 7:30p.m. documents, "Resident is confused. Doesn't know where she is, writer attempted to reorient resident, it didn't help. Resident unable to follow writer's fingers, grasping at things that aren't there. At (7:33p.m.) writer called MD (physician), gave orders to send to hospital." R1's progress note dated 3/17/22 at 10:32a.m. documents that nursing staff called the hospital for an update on R1's condition and were informed R1 had sustained a "right side hemorrhage."

On 7/18/22 at 2:23p.m. V3 stated she was R1's nurse on the day she fell 3/16/22. V3 verified that there was only one staff member in the room during R1's transfer. V3 stated that after R1 fell, V4 told her that after V4 had transferred R1 to the bed using the standing mechanical lift, V4 was pulling the mechanical lift away from the bed when R1 fell onto the floor. V3 stated that the CNAs have transfer instructions that say R1 could be transferred using the standing mechanical lift using only one CNA but that they could choose to use the full mechanical lift with two CNAs if they thought R1 was having difficulty bearing weight. V3 stated it was up to the CNA to decide what kind of transfer R1 needed stating, " It was their choice." V3 stated she does not know why R1's care plan was changed on 2/15/22 to include using a mechanical lift with two staff for all transfers PRN. V3 stated that R1 was not able to sit up on the side of her bed independently and R1 also had a specialized mattress with a motor which fills the mattress with air and is used as a pressure ulcer prevention. V3 stated she thought R1 was steady while sitting up on the side of the bed but that, "No one should be left unattended on the side of the bed."

R1's fall investigation dated 3/16/22 to 3/18/22

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documents V4 (Certified Nurse Aide/CNA) was the staff member present when R1 fell on 3/16/22. This investigation documents that during V4's interview V4 stated that she used the standing mechanical lift to transfer R1 to a seated position on the side of R1's air mattress and when V4 released the mechanical lift straps from around R1, R1 was unable to remain in a sitting position and slid off the bed and onto the floor, striking R1's head. This same investigation documents R1's roommate, R4, was a witness to R1's fall. R4 stated that V4 transferred R1 to the bed using the standing mechanical lift. R4 stated that when V4 released the straps, R1 fell onto the floor and hit her head.

On 7/19/22 at 12:52p.m. V2 (Director of Nurses) stated she investigated R1's fall from the side of the bed on 3/16/22. V2 stated that when she interviewed V4, V4 stated that after she had transferred R1 to the bed using the standing mechanical lift, R1 was unable to sit up straight which caused R1 to fall. V2 stated that R1's roommate, R4, was interviewed and she confirmed that after R1 was transferred to the side of the bed by V4, R1 could not sit up straight and fell off the bed. V2 stated, " I don't think they (staff) knew (R1) was unable to maintain an upright position at that time."

R1's hospital records dated 3/16/22 to 4/1/22 document R1 was transferred to the hospital following a fall at the facility on 3/16/22 where she initially had a negative Computed Tomography Scan (CT) but returned to the hospital a second time on 3/16/22 with acute mental status changes at which time another CT was performed which showed R1 had sustained Right Superior Temporal Intraparenchymal Hemorrhages. This hospital record documents R1 was not a surgical

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S9999	Continued From page 8 candidate but remained in the hospital for 16 days during which time R1's condition deteriorated. R1's hospital discharge summary documents R1 was referred to Hospice for comfort measures at the time of discharge. R1's Radiology report dated 3/16/22 documents R1 received a CT scan for "Worsening confusion after a fall today." This CT scan documents R1 had sustained a 4.3cm (centimeter) x 3cm right superior temporal intraparenchymal hemorrhage with surrounding edema "and "additional small focus of cortical hyperintensity within the lateral right frontal lobe which could reflect additional hemorrhage." R1's Death Certificate dated 4/16/22 documents R1 died at the facility on that date with a cause of death due to Intracranial Hemorrhage. (A)	S9999		