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	IL6009740	A. BUILDING: _____ B. WING _____	C 06/10/2022

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S 000	Initial Comments Facility Reported Incident of 5-27-22/IL147655	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 2): 300.690b) 300.690c) Section 300.690 Incidents and Accidents b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. This REQUIREMENT was not met as evidenced	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 by: Based on interview and record review, the facility failed to notify State Agency of serious resident injury for one (R5) of three residents reviewed for accidents in a sample of six. Findings include: The facility's Abuse Prevention Training Program policy, effective 11-22-17, documents "Serious Incident any incident or accident that has, or is likely to have, a significant effect on the health, safety, or welfare of a resident or residents. Incidents and accidents resulting in injury requiring the services of physician, hospital, or police, or other service provider on an emergency basis and/or requiring the services of the coroner or fire department shall be reported to the Department of Public Health within 24 hours of the incident or accident. Notification shall also be made by a phone call to the Department ' s Regional Office or if the facility is unable to contact the Regional Office, via fax or the Department ' s toll-free complaint number. A narrative summary of each serious accident or incident occurrence shall be sent to the Department within seven days after the occurrence." R5's Progress Note, dated 3-20-22 at 7:20pm, documents "Nurse called into resident room due to skin tear located to resident RLE (right lower extremity). (Mechanical lift) used as transfer, still in resident room." R5's Progress Note, dated 3-20-22 at 11:40pm, documents "Resident returned to facility...Resident received 5 sutures to laceration of right lower leg."	S9999		

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S9999	Continued From page 2 R5's Minimum Data Set/MDS assessment, dated 2-4-22, documents R5 is cognitively impaired and requires total dependence and two person physical assist for transfers. The facility's statement from V26 CNA on 3-20-22 includes "During transfer of (R5), (R5's) leg brushed up against the (mechanical lift) causing a skin tear." On 6-9-22, at 2:30pm, V1 Administrator stated that V1 cannot find any reportable completed for R5's incident on 3-20-22. V1 confirmed the cause of injury to have occurred during the mechanical lift transfer, that it was not reported and should have been. (C) Statement of Licensure Findings (2 of 2): 300.610a) 300.1210b) 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.	S9999		

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S9999	Continued From page 3 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. 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. This REQUIREMENT was not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure safe resident transfers for three residents (R1, R4, and R5) of six residents reviewed for falls and transfers in a sample of six. These failures caused R1 to sustain a left hip fracture and pain, and R4 and R5 to sustain lacerations requiring sutures. Findings include: The facility's policy Falls and Fall Risk, Managing,	S9999		

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S9999	Continued From page 4 revised August 2008, documents "Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling." 1. On 6-3-22, at 9:24am, R1 was in bed. R1 stated the following: "The girl (V6 Certified Nursing Assistant/CNA) was trying to fix my chair. I was trying to put my other hand on the walker and lost my balance. (V6) was adjusting the foot rest so it would stay up. I was getting out of the chair so they could work on it. (V6) couldn't catch me because (V6) had her back to me." R1's Progress Note, dated 5-22-22, at 7:23pm, V3 Registered Nurse/RN writes: "Staff (V6 CNA) reported observing resident during a fall in room." R1's Minimum Data Set/MDS assessment, dated 5-9-22, documents R1 as cognitively intact and requires one person physical assist for transfers and walking in the room. R1's MDS assessment also documents R1's balance during transitions and walking as "not steady, only able to stabilize with staff assistance" for moving from seated to standing position, for walking (with assistive device if used), for turning around and facing the opposite direction while walking, and for surface-to-surface transfers (transfer between bed and chair or wheelchair). On 6-3-22, at 11:40am, V6 CNA stated what occurred on 5-22-22: (R1) pressed the call light. I went in and (R1) was already standing up. (R1) was all upset because her recliner wasn't swiveling. (R1) was standing up at her walker. I was talking to (R1) and said let's sit down. I'll try to fix it...(R1) started back pedaling and shuffling	S9999		

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backwards and started to lose (R1's) balance. I tried to catch (R1), but it happened too fast...Supervision with limited assist is what (R1) is supposed to be, but sometimes (R1) does it by herself. Supervision means to be with (R1) and help her. (R1) can do a lot by herself...My intention was to sit her on the bed and then fix the chair.

On 6-3-22, at 1:30pm, V9 Certified Occupational Therapy Assistant/COTA assisted R1 to stand at the bedside three times with rest periods in between. R1 rubbed R1's left hip surgical area and stated, "it hurts." At this time, conversation between R1 and V9 included R1 stating "They thought that since I walk with a walker that I don't need help. But I did need help." V9 replied "Yes, you need them to help you."

R1's left hip X-ray report, dated 5-23-22, documents "Left hip slightly impacted subcapital fracture of left femoral neck with no significant displacement."

2. The facility's "Safe Lifting and Movement of Residents" policy, revised August 2008, documents "Policy Statement: In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses mechanical lifting devices for the lifting and movement of residents."

The facility's policy "Lifting Machine, Using a Portable, revised August 2008, documents "Purpose: The purpose of this procedure is to help lift residents using a manual lifting device. 1. Review the resident's care plan to assess for any special needs of the resident...3. To transfer a resident from a bed to a chair, you should...(m.) To position the resident comfortably in the chair,

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S9999	Continued From page 6 grasp the top of the sling with one hand and pull back on the sling while lowering the resident into the chair. (Note: You can also push gently on the resident's knees while lowering the resident into the chair)." On 6-8-22, at 10:24am, R4 was in bed with dressings noted to bilateral forearms and left lower leg. At this time V20 and V21 Certified Nursing Assistants/CNAs transferred R4 from his bed to a wheelchair using a mechanical lift device. On 6-8-22, at 10:30am, R4 stated the following occurred on 5-27-22: Two girls were getting me up (with the mechanical lift). When letting me down into the wheelchair they had not unhooked the hooks yet. One CNA (V18) was operating the lift and the other CNA (V17) was behind me tried to straighten me up and the (mechanical lift) fell and tipped over the top of me. It hit my arms and caused my left leg to hit against the wheel chair. Both arms got skin tears and my leg injury required sutures at the hospital. A CNA said it was a malfunction of the (mechanical lift). R4's current care plan includes "(R4) has impaired skin integrity to BLE (bilateral lower extremities) r/t (related to) multiple ruptured hematomas," date initiated 5-16-22. This focus has interventions/tasks including "Ensure resident's legs are supported during transfers," date initiated 5-11-22. This same care plan also documents "(R4) has a Transfer ADL (Activities of Daily Living) Self Care Performance Deficit r/t (related to) Limited ROM (Range of Motion). Goal: (R4) will transfer using safe technique to/from bed, wheelchair, with total x two assist with (mechanical lift) for safety by review date. Transfer: (R4) requires (mechanical lift) x two	S9999		

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S9999	Continued From page 7 staff for transfers." R4's Progress Note, dated 5-27-22 at 11:45am by V25 Licensed Practical Nurse/LPN, documents: "While transferring from bed to wheelchair with (mechanical lift), (R4) obtained skin tears on both forearms and on left leg. Left leg wound was bleeding profusely, and it was this nurse's opinion that resident be sent to ED (Emergency Department) for evaluation...Resident transferred to (hospital) via AMT (ambulance medical transportation)." The facility's final report to State Agency for R4 documents "On 5-27-22 at 11:45am (R4)sustained a laceration to left lower leg...Staff interviews noted that there were two CNAs and a (mechanical lift) was used to transfer (R4) to wheelchair...As (R4) was being lowered down into wheelchair, staff grabbed positioning straps on the (mechanical lift) to position (R4) in the wheelchair as that occurred the (mechanical lift) tipped towards (R4) when (R4) was right above the wheelchair, causing skin tears to right and left upper extremity and laceration to left posterior leg." R4's Minimum Data Set/MDS assessment, dated 5-11-22, documents R4 is cognitively intact, requires total dependence and two person physical assist, weighs 332 pounds and is six foot three inches in height. On 6-7-22, at 11:56am, V17 CNA stated the following occurred on 5-27-22: Therapy (V9 COTA/Certified Occupational Therapy Assistant) came in while we were getting (R4) up. Another agency CNA (V18) was there to help me. (V9) was just outside the room during the (mechanical lift) transfer. I said (R4) might need a bigger sling	S9999		

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and (V9) said there were none. (V9) was standing behind me, (V18) maneuvered the (mechanical lift), and I was holding onto the sling by the handles so (R4) didn't twist or turn in the air. While up in the air you have to pull on the sling to position (R4) into the chair. While we did that the (mechanical lift) tipped over while (V18) was trying to lower and I'm trying to align (R4). It fell over (R4's) head and was on its front wheels only, the other two were off the floor. It gashed (R4's) leg, a big gash. They had to call 911. It was bad. And both (R4's) arms had skin tears too...Not sure why it tipped. It wasn't (R4's) weight, it was the old (mechanical lift). And (R4) needed a bigger sling.

On 6-8-22, at 10:44am, V18 CNA stated the following: (On 5-27-22) I was in the process of transferring (R4) with another girl (V17 CNA)...We attached the (mechanical lift) and it made a funny noise but it seemed to be okay. It was making a clicking noise as we were lifting him off the bed as though it would break, but all was still okay. I was controlling the (mechanical lift) and (V17) had (R4) and was holding the sling. I extended the legs to the fullest and put it at the side of the wheelchair - one leg in front of the wheelchair and one through the middle. After making sure it was extended, we lowered (R4) into the wheelchair...The problem was with (R4's) weight. Once V17 CNA grabbed (R4's) weight by the sling, (R4) went properly into the wheelchair, but the mechanical lift fell on top of (R4) - tilted towards (R4) ...It didn't make sense. The (mechanical lift) was extremely old...If not mistaken I don't think the legs were locked. I don't think it had locks and don't recall locking it or seeing a lock for it. The shifter handle didn't lock. The legs never moved and were fully extended...The sling provided in (R4's) chair is

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too skinny for (R4). (R4) needed a wider sling. Whatever snagged (R4's) leg gashed it really bad.

On 6-7-22, at 1:53pm, V9 COTA (Certified Occupational Therapy Assistant) stated the following: (On 5-27-22) The CNAs were ready to get (R4) up and his chair was in the hallway so I put it in the doorway for them. I stepped out in the hallway and was observing. The back of the wheel chair was facing the doorway. They lifted (R4) up with the (mechanical lift) coming in on the side of (R4's) chair with one leg (of the lift) in between the front and back wheels and second leg (of the lift) out in front of the chair. (R4) was positioned over a reclining type of. One CNA (V17) was at the back of (R4's) chair and one (V18 CNA) was operating the (mechanical lift). Once (R4) was elevated and positioned over the chair the other CNA (V17) reclined the chair. (V17) took the handles at the sides of the sling and pulled him back to position (R4) to go down and that's when the (mechanical lift) tilted towards (R4) on its side and took (R4) into the chair - (R4) rapidly descended into the chair, cockeyed a little, and (R4's) legs were off center.

On 6-9-22, at 10:33am V9 COTA confirmed that during (R4's) transfer on 5-27-22, V9 didn't see any CNA supporting (R4's) legs. V9 stated that V9 did not see (V18's) hands on (R4) during the lowering, only the (V17 CNA) who had her hands on the back of (R4's) sling to position (R4).

On 6-7-22 at 1:36pm, V10 Scheduler produced the educational material (located at each Nurse's station) and stated it is regarding (mechanical lift) transfers and was used for the in-service held after (R4's) incident. These education material handouts titled "How to Use a (Mechanical) Lift"

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S9999	Continued From page 10 were located at each nursing station. Number 9 on page 4 documents "Practice good lifting technique. The (mechanical) lift does most of the work for you, but you will still need to move the user in and out of the sling. You should follow safe lifting practices to minimize risk of injury." On 6-9-22 at 1:56pm, V13 Resident Care Coordinator stated that the following occurred on 5-27-22: At the end (of R4's transfer) when pulling the sling back, the bars of the mechanical lift bumped (R4's) wheelchair which caused (R4's) weight shifting back and caused the (mechanical lift) to tip. Our intervention was education on proper positioning, how to utilize it, and locking the brakes on the lift. They did not lock the (mechanical lift) with the locks it has at the bottom manually. They should have locked it once in position and centered over the top of the wheelchair to go down into it correctly. On 6-9-22, at 2:10pm, V1 Administrator stated the following: The mechanical lift with the scale #8 was used on (R4 on 5-27-22) and it is one of our own (mechanical lifts). No one told me it made a clicking noise. It shouldn't click but it may squeak since it's hydraulic...No one said the sling used was too small. (R4's) sling was at the back of (R4's) knees and top of (R4's) shoulders which was proper placement - I saw it. V1 confirmed (R4) received skin tears to each arm and left leg; left leg laceration required sutures. V1's email stated "The (mechanical lift) did not malfunction and nothing was broken. It was due to the shifting of the weight of the resident." On 6-7-22, at 10:30am, R4 sat in a wheelchair in his room. R4 stated the following: On May 11 or 12th, I was sitting in a wheelchair. A CNA (V24)	S9999		

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was putting my feet up on the leg rests. (V24) had my left one up, grabbed my right one by my calf and caused a skin tear that needed stitches at the hospital. (V24's) hand pulled the skin right off as (V24) raised it. My skin is very fragile. The actual report said it was the wheelchair, but I sent a correction that it was (V24's) hand that pulled off my skin.

The facility's final report to State Agency for R4 documents: "On 5-11-22 at 5:30pm, (R4) sustained a skin tear to right posterior leg...(R4) sent to Emergency Room...(R4) returned to facility with a noted 10 centimeter skin tear to right posterior leg. 10 sutures and 4 steri-strips were used to repair skin tear...Two CNAs and a (mechanical lift) was used to transfer (R4) to chair. Staff interviews also note that they did not hit (R4's) leg on any object. Upon completion of the transfer CNA noted blood on (R4's) right leg."

The facility's statement from V24 CNA on 5-12-22 includes that after another CNA and (V24) did a mechanical lift transfer from bed to wheelchair, "(V24) placed the foot pedals on (R4's) wheelchair, (R4's) left foot went up perfectly, the right foot didn't, as I held on with both hands to (R4's) leg, (R4's) leg was about to bend and be placed correctly on the wheelchair but it didn't and (R4's) leg slipped from the foot pedal and I lost grip and (R4's) skin tore."

On 6-9-22, at 2:22pm, V13 Resident Care Coordinator stated that (V24 CNA) had said that (R4's) leg was big and swollen with edema. V24 said V24 lost her grip, (R4's leg) didn't hit anything, but (V24) looked down and (R4's) leg was bleeding. (R4's) skin is very fragile so even the lightest touch could do that to (R4's) legs. Could have been her hands.

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WASHINGTON SENIOR LIVING	1201 NEWCASTLE WASHINGTON, IL 61571

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S9999	Continued From page 12 3. On 6-7-22, at 9:56am, R5 sat in a wheelchair in her room. V14 and V15 CNAs transferred R5 from the wheelchair to (R5's) bed using a mechanical lift. R5's Minimum Data Set/MDS assessment, dated 2-4-22, documents R5 is cognitively impaired and requires total dependence and two person physical assist for transfers. R5's Progress Note, dated 3-20-22 at 7:20pm, documents "Nurse called into resident room due to skin tear located to resident RLE (right lower extremity). (Mechanical lift) used as transfer, still in resident room." R5's Progress Note, dated 3-20-22 at 11:40pm, documents "Resident returned to facility...Resident received 5 sutures to laceration of right lower leg." The facility's statement from V26 CNA on 3-20-22 includes "During transfer of (R5), (R5's) leg brushed up against the (mechanical lift) causing a skin tear." (B)	S9999		