STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015499	A. BUILDING: _____ B. WING _____	C 11/04/2022

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S 000	Initial Comments Complaint Investigation: 2297309/IL151145	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)3 300.1210d)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 care and personal care shall be provided to each	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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 were NOT MET as evidenced by: Based on interviews and record reviews, this facility failed to thoroughly assess and determine an acute change in condition leading to respiratory distress and failed to notify the physician immediately of a fracture. These failures affected 2 of 3 residents (R4, R1) reviewed for quality of care. These failures resulted in R4 having a change in respiratory condition and not immediately transported to the hospital for over 90 minutes where R4 was admitted with a diagnosis of acute respiratory failure, this failure also resulted in R1 having a radiology report of a leg fracture not being reported to the physician for over 5 hours which	S9999		

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S9999	Continued From page 2 delayed R1 being treated at the local hospital. Findings include: 1. R4: On 11/2/22 at 330pm, V16 (nurse supervisor) stated that V16 was called by the nurse in charge and informed that she was going to send R4 to the hospital. V16 stated that when V16 arrived at R4's bedside, V16 brought vital sign machine, nebulizer machine, and nebulizer medication. V16 stated that R4's oxygen saturation level was normal when he arrived. V16 does not remember any details of R4's respirations, but recalls R4 was congested. V16 stated that R4's blood pressure was quite elevated and R4 was responsive to name. V16 stated that R4's head of bed was elevated and a breathing treatment was administered. V16 stated that R4 was not in cardiac or respiratory distress. V16 stated that he was not aware R4's oxygen saturation level was 78% prior to V16 arriving at R4's bedside. V16 stated that he would have sent R4 out to hospital via EMS (emergency medical services) 911 if he had known that. On 11/2/22 at 3:45pm, V2 DON (director of nursing) stated that R4 was stablized with oxygen and did not require urgent transport to the hospital. V2 stated that R4 was not normally on oxygen therapy. When questioned regarding R4's breathing status (rapid, labored, or use of accessory muscles), additional vital signs, pulse oximetry results with and without oxygen, and lungs sounds, V2 did not respond. Review of R4's medical record notes the following: On 10/14 at 2:05pm, V20 LPN (licensed practical nurse) noted V20 was informed by R4's POA	S9999		

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S9999	Continued From page 3 (power of attorney) that R4 was noted to be lethargic and sounded like he was struggling to breathe. R4 was assessed and blood pressure 181/85, oxygen saturation level 78% on room air, respirations 22/minute. R4 was put on 4 liters of oxygen and oxygen saturation level went up to 94% on oxygen. R4's physician was notified and new orders received to send to hospital for evaluation and treatment. R4 was put to bed and head of bed elevated 45 degrees. V16 (nurse supervisor) assessed R4 and nebulizer treatment was given. A private outside ambulance service was contacted for transport, estimated time of arrival 1 hour. Will continue to monitor R4's condition for any changes On 10/14 at 2:57pm, R4's chest x-ray results show heart is slightly enlarged with mild congestive heart failure and possible pnuemonic infiltrate in the right lung base. Results faxed to R4's physician, R4 remains with order to send to hospital. On 10/14 at 3:25pm, V20 noted private outside ambulance service arrived at 3:10pm to transport R4 to the hospital. Review of the private outside ambulance service run sheet, dated 10/14/22, notes dispatch was contacted at 1:43pm for transport to hospital for resident with high blood pressure. An ambulance was dispatched to this facility at 2:26pm. Paramedics were at R4's bedside at 3:09pm. The ambulance did not leave facility with R4 until 3:43pm. R4 arrived at the hospital at 4:02pm. The paramedics noted: chief complaint severe respiratory distress. Vital signs at 3:11pm, oxygen saturation 76% on room air, respirations 24/minute and labored. Narrative note: responded to this facility for a male resident (R4) complaining of lethargy and evaluation for high blood pressure. Assessment showed R4 was	S9999		

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S9999	Continued From page 4 mouth breathing and had labored breathing. R4 was placed on a non-rebreather mask with 15 liters of oxygen and oxygen saturation 98%. R4 is less labored and less agitated on non-rebreather mask; R4 was receiving 3 liters of oxygen via nasal cannula upon paramedics arrival at R4's bedside. R4 was admitted to hospital with diagnosis: acute respiratory failure. R4 expired in hospital. 2. R1: On 11/2/22 at 3:45pm, V2 DON (director of nursing) stated that R1 did not complain of pain in left hip so did not need to be transferred to the hospital urgently. When questioned if V2 assessed R1's leg for pain with slight movement, V2 did not respond. V2 was informed that V17 NP (nurse practioner) noted R1 grimaced with slight movement of left leg. Review of R1's medical record notes the following: On 9/1 at 3:35pm, V15 RN (registered nurse) noted: R1 was seen by V17 NP (nurse practitioner), new orders received; x-ray of left hip, left Femur, left knee, left lower leg,and left foot due to left foot swelling. Order placed with outside diagnostic imaging company. On 9/1 at 4:23pm, V17 NP noted: R1's family member reports that R1 has been guarding left leg. R1 was sleeping. R1 did grimace upon exam. Left lower extremity with 2+ non-pitting edema (swelling). Range of motion not performed as R1 grimaced upon slight movement. Left leg pain and swelling, x-rays of left hip, femur, tibial/fibula, ankle, and foot to be done. On 9/2 at 2:28am, V18 LPN (licensed practical	S9999		

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nurse) received results from the outside diagnostic imaging company. Findings for left hip: Left inter-trochanteric fracture and superior subluxation and impaction.
On 9/2 at 2:36am, V18 LPN noted: Faxed to V13 (attending physician) and will endorse to incoming shift.
On 9/2 at 8:08am, V11 RN contacted V17 NP regarding X-ray results. Order received to send R1 out to the hospital for further evaluation. R1's family member notified. R1 was picked up by a private outside ambulance service at 9:15am.

Review of R1's hospital record, dated 9/2/22, notes R1 presented to the emergency room at 9:51am. It notes reason for admission: left hip fracture, age-related osteoporosis without current pathological fracture. The emergency room physician noted R1's left leg is internally rotated, flexed at knee and hip, limited range of motion due to pain. Left leg x-rays noted evaluation of left lower leg is somewhat limited secondary to osteopenia. There is an intertrochanteric fracture, comminuted with impaction of the distal fracture fragment and medial angulation.

On 11/1/22 at 10:47am, V19 (R1's family member) stated that V19 was present on 8/26/22 when V21 CNA (certified nurse aide) transferred R1 from reclining wheelchair to bed. V19 stated that V21 CNA grabbed R1's arms, V19 asked about mechanical lift device, V21 CNA responded 'I can lift her myself'. V19 asked 'shouldn't you be grabbing R1 under armpits?' Before V19 could get to other side of bed to assist V21 CNA, V21 CNA threw R1 into bed, R1 was half on and half off the bed. V19 stated that V19 assists the CNAs with incontinence care of R1. V19 stated that R1 is essentially nonverbal, only speaks one or two words, but looked at V19 like she was

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S9999	Continued From page 6	S9999		

scared. V19 stated that V21 spread R1's legs apart, like R1 was a wishbone. After R1's brief was changed, V21 CNA threw R1 back into the reclining wheelchair, again R1 was half on and half off chair. V19 stated that V19 saw another CNA in R1's doorway and called out for assistance. The other CNA, V9, stated that he would get the mechanical lift device to transfer resident to bed. V19 stated that she told V9 CNA that R1 did not need the device and asked his assistance with getting R1 positioned better in wheelchair. Stated that V21 CNA informed V9 CNA that R1 was fine like she was, V9 CNA assisted anyway. V19 stated that once R1 was positioned better in wheelchair, V19 took R1 to nurses' station to speak with V2 DON (director of nursing) regarding situation. V19 stated that family had to request x-rays of R1's left leg and inform staff of swelling to left foot. V19 stated that on 9/2 V19 requested further x-rays due to R1's grimacing with slight movement of left leg. V19 stated that R1's left hip was shattered. R1 had surgery on 9/3/22.

On 11/2/22 at 11:55am, V2 DON stated that per this facility's transfer protocol R1 requires a mechanical lift device and two staff members for transfers. V2 stated that V21 CNA disregarded this facility's transfer protocol. V2 stated that on 8/26/22, V21 was sent home after the incident. V2 stated that V2 and V5 (human resources director) met with V21 on V21's next scheduled day to work. V2 stated that V21 informed V2 that she transferred R1 without a mechanical lift device. V21 informed V2 and V5 that V21 transferred R1 by herself because she thought R1 was light enough to transfer by herself. V2 stated that V21 was aware of the transfer codes that are on each resident's door and that all staff will follow a resident's transfer status as assessed

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S9999	Continued From page 7 by the restorative nurse. V2 stated that R1's transfer code was orange for mechanical lift device required. On 11/1/22 at 1:25pm, V6 (restorative nurse) stated that she is familiar with R1. V6 stated that R1 did not walk, unable to bear weight, unable to stand pivot, and required a mechanical lift for transfers. V6 stated that there is a color code with each resident's name on his/her door. V6 stated that R1 had an orange dot next to her name indicating mechanical lift device required. V6 stated that all staff receive color coding training and transfer technique upon hire and annually. V6 stated that staff have to provide return demonstration during competency. V6 stated that V6 is aware of V21. V6 stated that V21 received training upon hire in April 2022 On 11/1/22 at 2:05pm, V8 CNA stated that R1 was not able to walk, was totally dependent on staff for transfer, and required a mechanical lift device and two staff members for all transfers. V8 stated that both of R1's legs were stiff. V8 stated that all residents have color coded sticker dots on their door to indicate how they transfer and the number of staff needed. V8 stated that staff receive annual training on transfers, return demonstration required. V8 stated that V8 has assisted V21 with transfers a couple of times. V8 stated that V21 seemed unsure of herself. V8 stated that R1's family spoke with V8 the following day regarding V21's transferring R1 without the mechanical lift device. V8 stated that it was not safe to transfer R1 without lift device. On 11/1/22 at 2:15pm, V9 CNA stated that V9 did not assist with R1's care on 8/26. V9 stated that R1 requires a mechanical lift device for all transfers. V9 stated that there is a color coded	S9999		

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S9999	Continued From page 8 dot beside the resident's name indicating how the resident transfers. V9 stated that he was bringing food to R1 when family member asked him for help. V9 stated that he thought family wanted to get R1 in bed so he went to utility room to get the mechanical lift device. V9 stated that the transfer had already been done before V9 went to R1's room. V9 stated that when he returned to R1's room with lift device, R1's family informed him that the family wanted assistance with positioning R1 better in wheelchair. On 11/2/22 at 1:24pm, V12 PA (physician assistant for R1's orthopedic surgeon) stated that V12 reviewed R1's hip x-ray. V12 stated that it looks like R1's left hip fracture was caused by a combination of osteoporosis and rough transfer from wheelchair to bed and then back to wheelchair. Review of this facility's report notes on 8/26/22, all resident transfer status codes were in place on all resident rooms. V21 came into R1's room which was clearly labeled orange dot for mechanical lift required. V21 transferred R1 from wheelchair to bed to provide incontinence care. Instead of getting a co-worker to assist with mechanical lift, V21 scooped R1 up in her arms and placed R1 in bed. Once care provided, V21 again scooped up R1 and placed R1 back in wheelchair. On 8/29/22, V5 (human resources director) asked V21 if she knows the transfer codes and V21 responded she does. V21 stated that she thought R1 was light enough to carry by herself. V21 stated that R1 did not look too fragile and R1 didn't complain on transfer so no issue. V2 DON informed V21 that the restorative nurse makes recommendations on transfer staus and it is up to the CNA to follow the transfer status without making judgement calls.	S9999		

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S9999	Continued From page 9 Review of this facility's resident transfer/lift procedures policy, reviewed 11/17/2021, notes initial screeningwill be performed on all our residents to assess transfer and ambulation status. Ongoing evaluation and updates will be conducted as needed. Transfer status will be designated for each resident. Residents transfer status will be identified by a color coded dot on the outside of the door next to resident's name. (A)	S9999		