| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6003305 | A. BUILDING: _____ B. WING _____ | C 12/14/2022 |

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| FRANKLIN GROVE LIVING AND REHAB | 502 NORTH STATE STREET FRANKLIN GROVE, IL 61031 |

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| S 000 | Initial Comments<br><br>Complaint Investigation:<br>2219744/IL154094 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br>300.610a)<br>300.1210b)5)<br>300.1210c)<br>300.1210d)6)<br><br>Section 300.610 Resident Care Policies<br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br>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.<br>5) All nursing personnel shall assist and | S9999 | Attachment A<br>Statement of Licensure Violations | |

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| S9999 | Continued From page 1<br>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.<br><br>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.<br><br>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:<br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation, interview, and record review, the facility failed to transfer a resident in a safe manner for two of four residents (R1, R4) reviewed for transfers in the sample of 7. This failure resulted in R1 suffering a fracture of the right femur.<br><br>The findings include:<br><br>1. R1's face sheet lists R1's diagnosis of senile degeneration of the brain, fracture of lower end of the right femur (dated 11/18/22), hypertension, major depressive disorder, colostomy status, seizures, osteoarthritis, and glaucoma.<br><br>On 12/14/22 at 11:05 AM V3 (Certified Nursing Assistant/CNA) said on 11/17/22 she had R1 in her room in a shower chair. V3 had just showered | S9999 | | |

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| S9999 | Continued From page 2<br><br>R1. V3 said V5 (CNA) was in the room and was asked to assist to transfer R1 to bed using a total mechanical lift. V3 said V5 operated the lift control and V3 supported R1 during the transfer. V3 said R1's back was facing her so she could not see R1's extremities and their position. "I'm not sure if she hit the bed or if it (leg) got caught". "I think her (R1's) foot got caught and pulled. As soon as we turned, she said "my leg"". V3 said "something occurred during the transfer that caused her (right leg) injury". "Now, I make sure the (resident's) legs are in the correct position prior to the transfer". V3 said "V9 (CNA supervisor) did [mechanical] lift training with all of us a couple of days later. So now, even if I'm behind the resident, I make sure their legs are in a correct position". "Both me and V5 should have made sure (R1's) legs were the correct position prior to moving her". V3 said she did not document the incident anywhere in R1's record or for investigative purposes.<br><br>On 12/14/22 at 11:24 AM V4 (Licensed Practical Nurse/LPN), said she didn't witness what happened on 11/17/22 but initially documented in R1' record what was reported to her by V3. V4 said V2 (Director of Nursing/DON) asked her to reenter a note showing V4's assessment of R1 as opposed to what was reported to her. V4 said so the first note was struck out and she entered a second progress note later in the day on 11/17/22 with her assessment. V4 said R1 was in obvious pain and was able to say where the pain was but not what had occurred. R1 was confused. "I believe something happened to cause her pain; I could tell. R1's voice was strained, and her breathing was heavier".<br><br>On 12/14/22 at 11:33 AM V5 (CNA) said on 11/17/22 she helped V3 transfer R1 with the total | S9999 | | |

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| S9999 | Continued From page 3<br><br>mechanical lift. V5 said she was "running" the lift. R1 did not complain of pain prior to the transfer. R1 "caught her right leg on something" and "said she was in pain. She (R1) complained of right knee pain". "I believe they (legs) were caught in the way when we were maneuvering her from the shower chair to the bed. Maybe the legs were on the wrong side of the lift. Now, I pay more attention to where the resident's extremities are". V5 said she didn't really see what happened.<br><br>On 12/14/22 at 11:40 AM V10 (R1's physician) said a resident's legs should be together (when being transferred with a lift). You shouldn't be able to catch your leg (on something). On 11/17/22, R1 suffered a right femur fracture. I didn't order an X-ray right away. It was thought to be a soft tissue injury initially. The mechanism of injury was the leg got caught and spread. R1's lower legs were contracted. I would expect staff to safely transfer a resident. Getting a resident's leg caught on something is not a safe transfer.<br><br>R1's face sheet showed admission to the facility on 9/23/15.<br><br>R1's 11/17/22 6:31 AM original nursing note (authored by V4 LPN) was struck out and showed: during transfer from shower chair to bed, residents legs got caught on either side of (mechanical) lift causing them to extend further than comfortable when staff began to turn her to place her in position for transfer. Resident exclaimed pain when staff began transfer. Staff then realized the position legs were in. Legs placed into proper position and resident assisted to bed. Bilateral legs examined once in bed. It is noted that the right knee and leg appears to be larger than the left especially at the knee. Assessed for pain which she rates a 10 to right | S9999 | | |

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| S9999 | Continued From page 4<br>hip and back. Resident difficult to assess ROM (range of motion) as she is normally contracted.<br><br>On 12/14/22 at 10:59 AM V2 (DON) said she wasn't sure why R1's initial nurse note was struck out and a new one entered later in the day. "Sometimes they put stuff that doesn't belong there. Nobody told her to remove it".<br><br>R1's 11/17/22 nursing note (authored by V4) and created after 4:00 PM, showed resident in bed c/o (complains of) right hip and back pain. Bilateral legs examined. It is noted that the right knee and leg appears to be larger than the left. Assessed for pain which she rates a 10 to right hip and back. Resident difficult to assess ROM as she is normally contracted.<br><br>R1's 12/4/22 physician order sheet showed an order dated 4/29/19, may use mechanical lift for transfers.<br><br>R1's fall care plan showed R1 requires full mechanical lift with two assistants for all transfers. R1 is totally dependent on staff for her locomotion.<br><br>R1's self-care performance deficit care plan showed R1 was totally dependent on two staff for transfers, bathing/showering, bed mobility, and toilet use.<br><br>R1's 7/20/20 care plan showed R1 at risk of impaired cognition related to dementia.<br><br>R1's 9/28/22 facility assessment showed moderately impaired cognition and total dependence on two plus persons physical assistance for bathing, toilet use, and transfers. | S9999 | | |

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| S9999 | Continued From page 5<br>The facility's 11/17/22 incident reported to the State agency showed R1 complained of right hip and leg pain after a transfer to bed. This reported incident showed R1's X-ray report stated acute fracture of the right distal femur.<br><br>The facility's 6/24/22 Using a Mechanical Lift Policy showed to assist the resident in guiding his or her legs. Be sure the resident is turned in such a manner that the resident is facing you. Do not pull the resident backwards.<br><br>The facility's investigation and root cause analysis documents were requested for review and not received.<br><br>The facility's November incident/accident log did not include R1's 11/17/22 incident.<br><br>The facility's 11/17-11/18/22 Record of Inservice Education showed staff were educated on (mechanical) lift transfer, reviewed safe lifting and movement of residents.<br><br>The facility's 11/18/22 mechanical lift competency assessment record showed V3 was educated on the proper placement and height of the (total mechanical lift) on 11/17/22.<br><br>The facility's 11/17/22 mechanical lift competency assessment record showed V5 was educated on the proper placement/awareness of resident limbs and height of mechanical lift during transfers.<br><br>2. R4's face sheet listed R4's diagnosis of heart failure, Type 2 diabetes, obesity, dysphagia, history of COVID-19, anxiety disorder, major depressive disorder, and chronic obstructive pulmonary disease. | S9999 | | |

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| S9999 | Continued From page 6<br><br>On 12/14/22 at 10:00 AM V7 (CNA) was in R4's bathroom with R4. R4 stood upright and V7 was cleaning R4's bottom. R4 was barefoot and had a dressing to the left great toe area. R4 said "I'm slipping". V7 had a gait belt around her own waist. V7 assisted R4 to turn and sit in a wheelchair without using the gait belt.<br><br>On 12/14/22 V2 (DON) said residents should have something on their feet during a transfer if they stand, for safety. Gait belts should be used for transfers to ensure resident safety.<br><br>R4's 10/13/22 Mobility Assessment showed R4's walking (with assistive device if used), moving on and off the toilet, and turning around and facing the opposite direction was not steady, only able to stabilize with staff assistance.<br><br>R4's 10/13/22 fall risk assessment showed a high risk for falling.<br><br>R4's 10/13/22 facility assessment showed severe cognitive impairment and required extensive assistance of one-person physical assistance to transfer, walk in room, and toilet.<br><br>R4's fall care plan showed to ensure R4 is wearing appropriate footwear when ambulating or mobilizing in wheelchair. R4 is to ambulate with one assist, gait belt, and use of rolling walker. R4 to transfer with one staff assist, use of gait belt and rolling walker.<br><br>R4's potential for alteration in skin integrity care plan showed R4 had poor safety awareness.<br><br>The facility's 4/26/22 Safe Lifting and Movement of Residents Policy showed gait belts should be | S9999 | | |

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| S9999 | Continued From page 7<br>used on residents unless residents are independent with ambulation or contraindicated in the resident's care plan.<br><br>"A" | S9999 | | |