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S 000	Initial Comments Complaint Investigation 2347065/IL163613	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a) 300.1210b) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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	S9999		

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S9999	Continued From page 2 and assistance to prevent accidents. These Requirements were not met evidenced by: Based on interview and record review, the facility failed to perform a safe transfer for 1 of 5 residents (R3) reviewed for resident injury in the sample of 6. This failure resulted in R3 sustaining a left tibial and fibular fracture which required hospitalization for surgical intervention. Findings include: R3's Face Sheet documents she was admitted to the facility on 6/8/23 with the diagnoses of Type 2 Diabetes Mellitus, Chronic Embolism and Thrombosis of Unspecified Deep Veins of Left Lower Extremity, Unspecified Protein-Calorie Malnutrition, Muscle Weakness, Other Abnormalities of Gait and Balance, and Other Age-Related Physical Debility. R3's Physician Order dated 8/27/23 documents the order: Send to (local hospital) to eval and treat left lower leg abnormality. R3's Minimum Data Set (MDS) dated 6/15/23 documents she is moderately cognitively impaired and requires extensive assist of one staff to transfer. It further documents R3 is not steady, and is only able to stabilize balance with staff assistance during surface to surface transfer (transfer between bed and chair or wheelchair). R3's Care Plan dated 6/16/23 documents, " Resident at risk for falls/contractures related to need for assistance with personal care,	S9999		

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weakness." The intervention for this care plan is, "Maintain a safe environment to room/facility to prevent injuries, well lit environment. Observe resident for any unassisted transfers/ambulation status. Remind to wait for assist and assist resident prn (as needed). B&B (bowel and bladder) before meals/after and prn. Keep resident clean and dry. Instruct/remind resident to use call lights when assist needed. Report any unsteady balance/gait to nurse/physician prn. Report any decline in safety awareness to nurse prn. Use of side rails times___ checked every two hours and prn."

R3's Kardex dated 6/16/23 documents, under transferring, "Transfer: The resident requires extensive assistance by (1) staff to move between surfaces."

The Facility's document, Incident Report, documents the date of R3's incident at 8/27/23 at 3:15 PM in her room. It documents, "Incident: CNA (Certified Nursing Assistant) (V10) alerted nurses (V5, Licensed Practical Nurse (LPN) and (V4, Registered Nurse (RN)) that (R3) complained of left lower extremity pain. (V5) went to her room and observed (R3) sitting up in wheelchair (w/c) with left lower extremity appearing hyperextended and appeared abnormal. (V10) statement indicated that after transferring (R3) as indicated on Kardex with gait belt, once she was in her wheelchair, she complained of pain then (V10) notified the nurse. Per (R3) she told the nurse that her leg was caught beneath her. (V4) assessed leg also and order was given to send to (local hospital) for evaluation and treatment. POA (Power of Attorney) was aware. DON (Director of Nursing) notified and Administrator notified."

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V10's handwritten statement was included in the incident investigation provided by V1, Administrator, on 8/29/23 and in this statement V10 documented, "On 8/27/23 I was assisgned B hall which included (R3). During first rounds I went into check on (R3) to see if she needed anything at that time. She asked if she could get up to go to Bingo. I told he that it would be no problem and proceeded to get her up for Bingo. (R3) did not complain of any pains prior to getting her up. Before transferring (R3) from her bed to her chair I explained to her step by step what I was doing. She agreed with things and seemed to be okay. I counted to 3 before lifting (R3) up and proceeded to put her into her chair. Once (R3) was in the chair she complained of leg pains. I told (R3) to give me a minute while I get the nurse. I got the nurse and notified the nurse of (R3's) complaints. I was not aware of (R3's) leg before putting her into her chair." V10's statement did not document that she used a gait belt when transferring R3 from her bed to the wheelchair.

R3's x-ray report dated 8/27/23 at 5:44 PM documents R3 has acute proximal tibial and fibular diaphyseal fractures with slight displacement and angulation.

On 8/29/23 at 9:00 AM, V1 Administrator stated she is aware of R3's left leg fracture from her Power of Attorney (POA) yesterday. She stated V2 DON, had called him to inform him of R3's injury that occurred during transfer. V1 stated she has sent the initial report and V2 DON is still investigating the incident.
V2 DON, was also present during this interview and stated the only thing she can think may have happened is that R3's leg got tangled up in the blankets during the transfer or her foot may have gotten tangled up in the chair. She stated she is

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only guessing because she really does not know what happened. V2 stated the nurses noted swelling to R3's leg and sent her to (local hospital) and she has been transferred to outlying hospital for an ortho consult. V2 stated they had the choice to do a mobile x-ray or send her to the emergency room (ER) and they sent her to the ER for a quicker assessment. V2 stated the CNA who transferred R3 is an agency CNA and she thinks it may have been her first time working in the facility. V2 stated R3 is alert and oriented x 2-3; she has good days and bad days. V2 stated R3 yelled out with everything, if she wanted something or wanted to know what was going on with her brother.

On 8/29/23 at 9:55 AM, R6, R3's brother and roommate, stated R3 did not fall; the CNA was transferring her from the bed to the wheelchair and right away she (R3) hollered, but he didn't think anything of it because she hollers every time they transfer her. He stated R3 stated, "It hurts so much" and when he looked at her, her foot was out at an angle. He stated R3 stated when the CNA transferred her, her leg was underneath of her, but he didn't know if she meant it was under her or under the wheelchair. R6 stated he was in the room when R3 was transferred, but he didn't look up until she was already in the wheelchair. R6 stated he did not see what happened. R6 stated the CNA was a little stunned and had the nurse in there checking her out about 30 seconds later. R6 stated the nurse came right in and checked her out and gave her Tylenol while the other nurse called the ambulance. R6 stated again that he didn't see what happened but maybe her (R3's) foot got caught. R6 stated his other brother called him to ask what happened because the hospital said both of the bones in her lower leg are broke. R6 stated it happened when

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the CNA was getting her out of bed and into her chair to go down to the dining room. R6 stated after the nurse checked R3 out, she transferred her back to bed and the ambulance came and got R3 about 4:00 PM. R6 stated his brother told him R3 is going to have surgery.

On 8/29/23 at 10:10 AM, V4 RN stated, at about 2:55 PM on 8/27/23 (V10) CNA had transferred R3 from bed to her wheelchair. V4 stated you could see the deformity right away when looking at R3's left leg. V4 stated R3 told her at first that this happened when the girl laid her down, but then said it happened when they got her up. V4 stated R3's leg is contracted and thinks it may have gotten tangled up in the blankets. V4 stated the CNA called the nurses in immediately when R3 said she was hurt. V4 said the CNA said when she was transferring R3, she said, "Oh my foot's caught." V4 stated V10, the agency CNA, transferred her on her own because R3 only weighed about 90 pounds. V4 stated when she went into R3's room, the CNA had R3 sitting up in her wheelchair. V4 stated she asked R3 if she was able to move her left leg and R3 lifted it up some and V4 was able to see the protrusion. She stated this happened on Sunday night and they sent her to the local hospital and she heard they were transferring her to (an outlying hospital) to determine if they were going to repair it. V4 stated R3 had said her foot was caught but she (V4) didn't know what it was caught on. V4 stated R3 hadn't had any falls and didn't try to get up by herself .

On 8/29/23 at 10:23 AM, V7 CNA stated, R3 usually transferred just fine with one assist, but if they were transferring her to the shower chair they would use 2 staff just because of floor being wet, to make sure she was safe. V7 stated she

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was able to transfer R3 on her own but often used another staff just because R3 sometimes freaked out because she was scared she would fall. V7 stated R3 was able to follow directions when they transferred her . V7 stated she uses a gait belt when transferring R3 because she is unsteady.

On 8/29/23 at 10:20 AM, V8 CNA stated, R3 required one assist and a gait belt for transfers. V8 stated R3 could stand pretty good and followed simple commands and was cooperative with staff.

On 8/29/23 at 10:22 AM, V9 CNA stated, R3 was not combative or resistive. V9 stated R3's legs are contracted and hyperextended but she is still able to stand with assist. V9 stated she doesn't ever know R3 to get tangled in her blankets. V9 stated if R3 had a problem during a transfer, she was able to let you know. V9 stated R3 would be able to stand or could easily be transfered to the bed or wheelchair, but you have to use a gait belt because she was unsteady.

On 8/29/23 at 10:41 AM, during phone interview, V10, Agency CNA stated she was working evenings on 8/27/23 when incident with R3 occurred. V10 stated it was right at the start of her shift and she was doing her rounds and R3 asked to be gotten up so she could go to Bingo. V10 stated she talked to R3 about how they were going to transfer and counted 1-2-3 and then transferred R3 to her wheelchair. V10 stated the other staff told her R3 was a one person assist for transfers. V10 stated she transferred R3 to her wheelchair and as soon as she sat down in her chair, R3 complained of her knee, stating "my leg, my leg , it hurts." V10 stated she immediately went and got the nurse. V10 stated as soon as

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the nurse started assessing R3, she (V10) went to finish her rounds. R3 stated when she did R3's actual transfer, both of R3's feet were on the floor. V10 stated R3 did not help a lot with the transfer but her feet were not tangled in the blanket. V10 stated R3 did not complain of any pain until she was sitting in her chair. V10 stated she did not use a gait belt while transferring R3 because nobody told her R3 needed a gait belt with transfers.

On 8/29/23 at 2:12 PM, V5 LPN, during phone interview, stated, " I honestly don't have a clue what happened to (R3's) leg." She stated the CNA came up to her and asked her to come help with R3 because she said her leg hurts. V5 stated as soon as she walked into R3's room she was sitting in her wheelchair and her left leg was grossly abnormal. V5 stated she talked to R3 to see what had happened and R3 gave her two different stories. V5 stated at first R3 stated when they laid her down in bed she told the girl that her leg hurt. V5 stated this would have been the day shift CNA who laid her down after lunch. V5 stated R3 said she told the girl her foot was "caught on me...it was under me." V5 stated she clarified this statement with R3, asking her if this was when they laid her down after lunch and R3 told her yes. V5 stated she had another nurse (V4) come in and assess R3, and she asked R3 to tell her again how it happened and R3 told her, "Well when she was getting me up I told her my foot was caught." (V5 stated it was actually just below R3's knee). V5 stated R3 stated she wanted to go play Bingo and she was getting up when she said it hurt. V5 stated R3 said her brother was in the room when it happened. V5 stated R3's left lower leg just below the knee was protruding to the left and her foot was hyperextended to the left. V5 stated the foot was

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red but she didn't see any bruising. V5 stated R3's legs are normally discolored. V5 stated while R3 was just sitting still she did not complain of pain, but if left leg was moved she said it hurt. V5 stated V4 was calling the doctor and the ambulance and she (V5) transferred R3 back to bed and she was fine during the transfer and getting into bed until V5 positioned her leg and that was when R3 said it hurt. V5 stated she did not talk to the CNA's from day shift because they were already gone. V5 stated R3 transferred just fine with one assist and a gait belt. V5 stated R3 was a pivot transfer and she is a very tiny person. V5 stated R3 required moderate assist to help her balance during transfers.

On 8/30/23 at 2:57 PM, V17 Emergency Room (ER) nurse from local hospital where R3 was initially sent, stated she is a night nurse and took care of R3 when she was brought to the ER with left leg fractures on 8/27/23. V17 stated R3 reported to her that she was being transferred to or from the bed or to or from the wheelchair and her leg got caught under the wheelchair and she told the staff to stop but they didn't and went ahead with transfer. V17 stated R3 is alert and oriented to self and knew she was in the hospital, and repeated the same story over and over again. V17 stated R3 had x-rays which showed a fibula/tibia fracture of the left leg. V17 stated it looked like a match stick. V17 stated the fracture was displaced and wiggling. V17 stated she was unable to reach R3's POA after several attempts and R3 was transferred to (outlying hospital) for ortho.

On 8/31/23 at 10:00 AM, V1 Administrator and V2 Director of Nursing stated V10 CNA should have been using a gait belt while transferring R3 from the bed to her wheelchair on her own. V1 stated

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V3 Assistant Director of Nursing always educates agency staff to bring their gait belt and where to park when they are scheduled.

On 8/31/23 at 4:53 PM, V18 R3's POA/brother, during phone interview, stated the facility nurse notified him on Sunday, 8/27/23 that (R3) was complaining that her leg hurt after she was transferred to her wheelchair and he was agreeable to her being sent to the hospital to have it checked out. V18 stated R3 was sent to the local hospital who then sent her to a larger hospital in the city. V18 stated this worked out well because there was a doctor there who was able to do surgery, which was done on Tuesday, and the doctor put a "band" on the larger bone which was connected to her knee on one end and her ankle on the other, and the doctor told him her smaller bone would heal along with the bigger bone. V18 stated R3's tibia and fibula were both broken. V18 stated R3 told him when the aide transferred her to her wheelchair, her foot got stuck and she yelled for the aide to stop but she went ahead and completed the transfer. V18 stated R3 told him it was only one girl transferring her from her bed to her wheelchair, but after she was hurt, two nurses transferred her back to bed. V18 stated he does not feel that aide had received appropriate training on how to transfer residents. V18 stated she (V10) should have gotten someone else to help her if she didn't know what she was doing.

On 9/1/23 at 10:46 AM V3, RN/ADON sent the following statement via email message :
"I understand the agency CNA may have said that she was not aware of gait belts being required while here. I do the CNA staffing and am right now only using one agency and that is (staffing agency name). They have an information

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page that any aid that books a shift here is to read prior to booking shifts and on that page it clearly states that gait belts are mandatory. Agency aids also sign in on a clipboard that is located on my office door and right beside the clipboard is a page typed in all caps that also states that gait belts are mandatory. Myself, and nurses on the floor, are also always on the look out to ensure that any aid has a gait belt and reminded to locate theirs if noticed not to be on their person."

On 9/1/23 at 12:28 PM, V19, Nurse Practitioner (NP) stated the facility had messaged on 8/27/23 her regarding R3's left leg swelling and she had given the order to send R3 to the emergency room for evaluation. V19 stated if the x-ray reports documented R3 had vascular calcifications, diminished osseous density and diffuse demineralization, this would have made her more susceptible to fractures. V19 stated she would expect the CNAs to use the gait belt when transferring residents who need assist for their safety.

The facility's undated policy, Fall Policy and Procedure, documents, "Policy: All residents have a right to be cared for within a safe environment. Each resident should be considered part of our fall prevention plan, which includes assessment of risk and initiation of appropriate interventions."

The facility's undated policy, Gait Belt Policy, documents, "The gait belt is a mandatory part of each aide's uniform. For the safety of the patient and the employee, aides are expected to use the gait belt whenever ambulating or transferring a patient. The gait belt will be worn around the waist of the staff member or be kept in the pocket when not in use throughout the scheduled shift.

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FREEBURG CARE CENTER	746 URBANNA DRIVE FREEBURG, IL 62243

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S9999	Continued From page 12 Gait belts will be used when helping the patient move from the bed, chair, or commode/toilet and to transfer and /or ambulate patients who need extra assistance. Direct care personnel will be trained in the proper use of the gait belt, primarily for safety purposes for both the staff and the patients. An employee who is injured or causes an injury to a patient as a result of failure to properly apply and use a gait belt is subject to disciplinary action, up to and including termination. The facility will supply a gait belt to any employee who does not currently own one (there may be a cost to the employee.)" (A)	S9999		