| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6005284 | A. BUILDING: _____ B. WING _____ | C 03/02/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| LEE MANOR | 1301 LEE STREET DES PLAINES, IL 60018 |

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| S 000 | Initial Comments<br><br>Facility Reported Incident of February 13, 2023 IL156860 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br><br>300.610 a)<br>300.1210 b)<br>300.1210 d)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>d) Pursuant to subsection (a), general | S9999 | Attachment A<br>Statement of Licensure Violations | |

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| S9999 | Continued From page 1<br>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>These requirements are not met as evidenced by:<br><br>Based on interview and record review, the facility failed to follow the Transfer Protocol by not ensuring a safe transfer from wheelchair to bed, which resulted in 1 resident sustaining a skin tear to right leg which required 9 sutures. This failure affected 1 resident of 3 reviewed for transfers (safety).<br><br>Findings include:<br><br>Initial Reportable, dated 2-14-23, documents: on 2-13-23 at around 8:40 AM, "Certified Nursing Assistant/CNA reported to the nurse on duty that the resident was bleeding from the right leg. Nurse noted a skin tear to her right leg due to transfer. Nurse on duty performed first aid and applied pressure to the site, covered with dressing, bleeding stopped. Called attending physician, received orders to send patient to local hospital for further treatment. Responsible party (POA) daughter was notified. at 2:00 AM, resident came back from ER with dressing to the right lower leg with sutures. Resident is alert and verbally responsive, not in any form of distress."<br><br>Final Reportable, dated 2-20-23, documents: "Conclusion: Interviews from staff that worked on the day of the incident were collected. CNA | S9999 | | |

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| S9999 | Continued From page 2 | S9999 | | |

recalled that the resident put the call light on around 8:35 PM. When the CNA entered the room, the resident asked to be put to bed from wheelchair because she is tired. According to the CNA assigned, he positioned himself adjacent to the bed, removed footrests from wheelchair, and properly transferred the resident from the wheelchair to the bed. As soon as the resident sat on the bed, resident mentioned that the right leg is hurting, When the CNA checked the leg, he noticed a skin tear with bleeding. CNA applied pressure to stop the bleeding, he called the nurse to assess the patient immediately. Nurse performed first aid and pressure dressing immediately, and bleeding has stopped. Nurse called MD and ordered to send to ER via 911. POA informed of the transfer to the hospital. Resident had sutures to the right leg per hospital report. Based on staff interviews, the team determined that R1's skin tear was unavoidable. The cause of the skin tear is due to the bed and patient's fragile skin. The resident's leg was touching the side of the bed during the transfer. Even though the resident is alert enough, (R1) at times can have poor safety awareness. There was enough lighting in the room and environment is clutter-free."

Hospital Record, dated 2-13-23, documents: "HPI (History of Present Illness): Patient is an 83-year-old female who presents to the ED (Emergency Department) with the skin tear on her right leg. Patient states that she is being transfer from a wheelchair to the bed when her right leg was caught. Laceration details: Location: Leg, Leg Location: R lower leg, Length (cm): 9, Treatment: Area cleansed with: Saline, Repair Method: Sutures, Suture Size: 4-0, Number of sutures: 9, Clinical Impression: ED Diagnosis: 1. Fall against object, 2. Laceration of right lower

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| S9999 | Continued From page 3<br>extremity, initial encounter."<br><br>On 3-1-23 at 11:11 AM, V2 (Director of Nursing/DON) said R1 is alert, oriented , and able to make her needs known; however, she has periods of forgetfulness and has mood swings. R1 will refuse or be uncooperative. V2 was not on duty during R1's accident on 2-13-23 at 8:05 PM. V2 was informed of R1's incident the following morning during morning report. This was immediately reported to the state by V2 when she was informed. V2 said R1 sustained cuts to her right lower leg, which could have been from the wheelchair or from the bed. R1's old bed was removed and replaced with a newer bed with rounded edges. R1 was given skin protectors for bilateral lower legs to provide protection, and staff was in-serviced on proper transfers.<br><br>On 3-1-23 at 10:42 AM, V4 (Certified Nursing Assistant/CNA) said he transferred R1 from chair to bed. R1 was in the wheelchair wearing a gait belt. V4 removed the wheelchair foot rests, bed was in low position, and bed side rails were down. V4 did stand and pivot transfer. During the transfer, R1 screamed about her leg. V4 put R1 in bed and noted bleeding to R1's left leg. V4 is not sure if the leg was cut from the wheelchair edge or bed side rail. V4 immediately notified the agency nurse. Agency nurse assessed and treated the bleeding immediately. V4 makes sure the legs are not coming into contact with the wheelchair or bed side rails. R1 has a new bed in place.<br><br>On 3-1-23 at 11:28 AM, V3 (Wound Nurse) said R1 has venous insufficiency (chronic) and diabetes. V3 said R1 has paper thin skin and fibrotic skin. The nature of the injury could be due to the edge of the wheelchair, or the edge of the | S9999 | | |

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| S9999 | Continued From page 4<br>bed. Facility provided a new bed with rounded edges, and facility ensures R1 will use bilateral skin protectors for protection of lowers legs.<br><br>Transfer Protocol/ Limited Lift Policy, revised June 2021, documents: Statement Policy: It is the policy of Lee Manor to attempt to protect both residents/patients and employees from injury in the course of transferring patients/residents.<br><br>(B) | S9999 | | |