Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014955	A. BUILDING: ______ B. WING ______	C 06/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PLAZA LISLE SNF	1800 ROBIN LANE LISLE, IL 60532

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S 000	Initial Comments Facility Reported Incident of May 23, 2023 IL160409	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 d)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 resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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.

These requirements are note met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure two staff assisted a resident during a mechanical lift transfer, and failed to utilize the proper sized equipment. This failure resulted in R1 sustaining a leg laceration requiring 11 sutures.

This applies to 1 of 5 residents (R1) reviewed for accidents and supervision in a sample of 5.

The findings include:

Face sheet, printed 6/12/23, shows R1's diagnoses include dementia without behavioral disturbance, anxiety, depression, syncope and collapse, urinary tract infection, and chronic kidney disease.

MDS (Minimum Data Set), dated 5/23/23, shows R1 was severely cognitively impaired, was totally dependent on two staff for transfers, and required the extensive assistance from staff for bed mobility, toileting, dressing, and personal hygiene.

On 6/12/23 at 1:00 PM with V5 (CNA - Certified

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S9999	Continued From page 2 Nursing Assistant) and V6 (CNA), R1 was transferred from her bed to her wheelchair, utilizing a mechanical lift and a large full body sling. R1 had a brown, dry wound that was long and linear on the back of her right calf. Initial and Final Report from the facility to IDPH (Illinois Department of Public Health), dated 5/23/23, shows R1 was unable to independently self-transfer or ambulate. The report shows R1 was transferred using a mechanical lift when she sustained a skin tear to the right calf area. The investigation report shows V4 (CNA) stated he identified blood on R1's leg after transferring R1 to her wheelchair, but was unsure what caused the injury. V4 stated V5 was assisting him at the time of the transfer, and he utilized the mechanical lift sling that was left on her chair in her room to transfer R1. The investigation shows V5 denied assisting V4 with R1's transfer at the time of the injury. The report shows R1 was transported to the hospital, where she received 11 sutures to help repair the skin tear. The report shows the facility determined during the transfer, the CNA utilized the wrong size sling, and there was only one staff present during the transfer, which was the root cause of the injury. On 6/13/23 at 5:04 PM, V7 (Physician) stated he had no reason to speculate otherwise that R1's laceration occurred during her mechanical lift transfer. V7 stated he had no reason to doubt the conclusion of the facility's injury evaluation that the wrong size sling and lack of two people assisting the mechanical lift transfer caused her laceration injury. V7 stated he examined R1 approximately two weeks prior, and had no concerns regarding lacerations. On 6/12/23 at 9:45 AM, V3 (LPN - Licensed	S9999		

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S9999	Continued From page 3 Practical Nurse) stated on the 5/23/23, R1 was brought to the dining room in her wheelchair at approximately 8:00 AM by V4 (CNA). V3 stated she noticed a mix of fresh and older blood on R1's pants and wheelchair leg board. V3 stated she pulled up R1's pant leg, and identified a large amount of fresh blood coming from a deep, open wound on R1's lower leg. V3 stated the wound looked deep enough to require sutures, notified R1's physician, and R1 was sent to the hospital for evaluation. V3 stated R1 was very confused, but was grimacing in pain, so V3 provided R1 with Tylenol for pain management. V3 stated she cleaned the wound, covered it, and called for transport to the hospital. V3 stated she measured the wound prior to hospital transfer to be 9 cm (centimeters) in length, however, the hospital measurements showed 12 cm when she returned to the facility. V3 stated she asked V4 how the wound occurred and V4 stated he did not know. Bruise and Skin Tear Investigation, undated, shows R1's injury was reported on 5/23/23 at 8:45 AM, when V3 (LPN- Licensed Practical Nurse) observed blood on R1's clothing and a 9.5 cm (centimeter) skin tear was observed on her right calf. The report shows an inappropriate transfer occurred, and R1 was transferred using an extra large sling instead of a large sling. Nursing note, dated 5/23/23, shows R1 was administered Tylenol for pain, the laceration was covered and protected, and R1 received an order to be transferred to the emergency department for sutures. Emergency Department records, dated 5/23/23, show R1 had a laceration to her right back leg measuring 12 centimeters below the left posterior	S9999		

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calf..

On 6/12/23 12:20 AM, V4 (CNA) stated the mechanical lift sling cut into R1 when he transferred her the day she was injured. V4 stated the full sling, not the two legged sling, was used, the R1's legs rested on the rough part of the mechanical lift sling, and the sling it dug into her skin. V4 stated he did not notice the injury at the time of the transfer, but noticed something red when he took R1 to breakfast afterward. V4 notified the nurse who assessed the wound and also examined the sling. V4 stated the sling was very long, thick and rough and V4 stated that day the sling dug into her leg. V4 stated an agency CNA assisted him with the transfer at the time of the injury, but could not recall the CNA's name.

On 6/12/23 at 9:38 AM, V5 (CNA) stated V4 asked her to agree to tell V1 (Administrator) she was in the room assisting with the transfer of R1, however, V5 declined to do so. V5 stated she was not present when V4 transferred R1 and R1 sustained her injury. V5 stated V3 (LPN - Licensed Practical Nurse) showed V5 R1's skin tear and V5 described it as "deep." V2 (DON-Director of Nursing) stated it was her expectation all mechanical lift transfers were to be performed with two staff assisting. V2 stated she determined V4 transferred R1 by himself the morning of the injury.

On 6/13/23 at 10:55 AM, V2 stated each CNA must use their judgement as to which sling should be used for each resident based on resident size.

On 6/12/23 at 9:20 AM, V1 (Administrator) stated his investigation of R1's injury showed R1 received her skin tear which required sutures

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during her transfer using a mechanical lift performed by V4. V1 stated initially, V4 stated he was assisted with the mechanical lift transfer by V5, however, when V1 interviewed V5, V5 denied assisting with the transfer. V1 stated his investigation concluded V4 improperly transferred R1 without assistance from a second staff, and V4 also utilized the incorrect size sling - both of which resulted in R1's injury.

On 6/12/23 at 10:33 AM, V2 (DON) stated V4 used a long and extra large sling to transfer R1 when she was injured and the sling was too long for the resident. V2 stated the CNA determines what size sling to use for a mechanical lift transfer resident based on resident size unless therapy makes a recommendation. V2 stated if staff use a sling that is too long, the sling rests lower on the resident's leg. V2 stated R1's injury was the back of the calf where an extra long sling would have rested and made contact with the leg. V2 stated V4 told V2 he noticed blood on R1's leg after he transferred her to the chair from her bed. V2 stated it was her expectation that all mechanical lift transfers are performed with two staff assisting and V2 stated she determined V4 transferred R1 by himself the morning of the injury.

Mechanical Lift User Instruction Manual, dated 2015, shows, "Always check the sling is suitable for he particular patient and is of the correct size and capacity."

Facility Mechanical/Assistive Lifts Policy, revised 9/2017, shows, "2. Use of all mechanical/assistive lift equipment should be according to manufacturer's recommendations .... 4. Associates should be educated on proper use of the equipment. 5 A manufacturer approved sling should be used during mechanical assistive

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S9999	Continued From page 6 transfers .... 9. Education should be provided on the proper use of the assistive mechanical lifting equipment prior to its use ...." (B)	S9999		