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
	IL6008213	A. BUILDING: _____ B. WING _____	C 12/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDWICH REHAB & HCC	902 EAST ARNOLD STREET SANDWICH, IL 60548

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S 000	Initial Comments Complaint Investigation #2319952/ IL 167230	S 000		
S9999	Final Observations Statement of Licensure Violations: 1of 3 300.610a) 300.1010h) 300.1210b) 300.1210d)3) 300.1210d)6) 300.3240a) 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including,	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. (B) 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 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.	S9999		

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S9999	Continued From page 2 Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements are not met as evidenced: A. Based on interview and record review the facility neglected to ensure a resident (R1) was assessed and provided pain management in a timely manner after being dropped from a mechanical lift on 11/21/23 at 5:30 AM which resulted in a right hip fracture. The facility neglected to notify the physician in a timely manner and provide ongoing nursing assessments, pain assessments, and pain management from the time of the incident on 11/21/23 at 5:30 AM through 11/22/23 at 1:25 AM (approximately 20 hours) when R1 was transported to the emergency department for evaluation and treatment of a right hip fracture. These failures resulted R1 being placed on bedrest without necessary care and effective pain management services being provided. R1 required medical evaluation and treatment at the hospital on 11/22/23 due to a right hip fracture sustained in a fall during a mechanical lift transfer at the facility. This applies to one of three residents (R1) reviewed for neglect in the sample of five. B. Based on interview and record review the facility failed to ensure a resident (R1) was safely transferred with a mechanical lift device. This failure resulted in R1 sustaining a hip fracture on 11/21/23 at 5:30 AM during a mechanical lift transfer after the lift device tipped over with R1 in the sling on the device. R1 required medical	S9999		

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evaluation and treatment at the hospital on 11/22/23 due to a right hip fracture that was sustained when the mechanical lift tipped over. This applies to one of three residents (R1) reviewed for safety in the sample of five.

The findings include:

1. The A.I.M. (Assessment, Intercommunicate, & Management) Event Record Late Entry for R1 for the incident on 11/21/23 at 5:30 AM showed there were two CNA's present, the mechanical lift tipped, and the resident fell. R1 was being transferred from the "shower to bed." New onset of pain; complaints of pain at the time of the event. The Practitioner, resident responsible party and facility management were not notified at the time of the incident. It happened around shift change so the nurse endorsed to the oncoming nurse to follow up. There weren't any other nursing assessments or pain assessments completed for R1 on 11/21/23.

The Health Status Notes for R1 on 11/21/23 showed, 2:50 PM - orders received for a portable x-ray. The Health Status Notes for R1 on 11/22/23 showed, 1:15 AM - Called 911 to get R1 transported to the emergency room; 1:25 AM emergency medical technicians x 3 to transport patient to the hospital.

The facility's Final Report dated 11/28/23 to Illinois Department of Public Health for R1's Incident on 11/21/23 showed, R1 sustained a ground level witnessed fall. Resident was immediately assessed by the nurse and sent to the hospital for further evaluation. R1 was diagnosed with a greater trochanteric fracture; surgical repair was noted to be not operative at this time per medical doctor. R1 returned to the

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facility with new interventions and pain management in place. Further consult was obtained; surgical repair was completed on 11/25/23. R1 is currently at the hospital and plans to return to the facility upon discharge. This is our final report. Signed by V1 - Regional Clinical Director.

On 12/1/23 at 9:15 AM V2 DON (Director of Nursing) stated she is the current acting DON. V3 LPN (Licensed Practical Nurse) stated she is the Resident Care Coordinator. V2 stated R1 was recently injured during an unsafe mechanical lift transfer. V2 stated they ultimately found out the floor was wet, and the mechanical lift fell over with R1 in the lift. V2 stated they found out about 20 hours later that R1 had a greater trochanter fracture (right hip fracture). V2 stated she found out on 11/21/23 at 2:30 PM from V5 CNA (Certified Nursing Assistant) and V6 CNA that R1 complained of back pain and was not feeling well. V2 stated she asked V5 and V6 if V9 (Licensed Practical Nurse) was told and they stated, "yes" and that R1 had been hurt during a fall that morning. V9 stated she knew R1 had a fall. V2 stated she texted V16 (Physician) at 2:47 PM and told him R1 had a fall and asked him for x-ray orders. V2 stated she didn't hear anything until the next day that an injury occurred. V12 CNA and V14 CNA were the CNA's that transferred R1 with the mechanical lift and they said it happened 11/21/23 at 5:30 AM. V10 LPN was the night nurse on duty, and she said that R1 was transferred by one CNA and not two CNA's. V3 stated she opened a risk management documentation and put in what she knew about the situation, and they are supposed to have two people for mechanical lift transfers because it is the facility's policy. V2 and V3 stated V10 LPN (night nurse) and V9 LPN (day nurse) did not

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S9999	Continued From page 5 document anything about what happened for the incident involving R1 or any assessments. V2 and V3 stated they were upset that they did not find out what happened to R1 right away and then all the different stories they were getting about what happened. V2 and V3 stated 4-5 days after the incident happened V10 LPN documented in R1's chart. V2 and V3 stated they did not take the legs off R1's wheelchair and that was part of the reason the mechanical lift tipped when they were maneuvering the lift around the legs and the floor being wet. V12 and V14 went to get V10 (LPN) after the fall. V12 stated V10 was asleep at the nurse's desk and would not know if 1 CNA did the transfer. V2 and V3 stated the CNAs should have removed the foot pedals and the mechanical lift they used gets stuck under the wheelchair due to the foot pedals. It affects the center of gravity and the mechanical lift tipped. It was an unsafe transfer and unsafe environment. On 12/1/23 at 10:29 AM, V9 LPN stated she came in at 6:00 AM and she did not know what time the incident with R1 occurred. V9 stated she got report from V10 LPN and was not told about R1's fall. V9 stated she did rounds at 6:30 AM and noticed R1 was sleeping. V12 CNA from nights was still here and told her that R1 fell. V9 stated she asked what was done and was told V10 LPN helped them get R1 up but did not do anything. V9 stated she reported it to V3 (Resident Care Coordinator), and she believes V3 notified V16 (Physician). V9 stated R1 had pain in both of her hips and in her lower back. V9 stated she doesn't remember if she documented an assessment. V9 stated they kept R1 in bed and told staff not to move her. V9 stated when a resident falls the CNA is to notify the nurse. The nurse does an assessment which includes vital signs, head to toe assessment, and range of	S9999		

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motion. They would get the resident up with a mechanical lift. They would notify the doctor and family right away. The DON and Administrator would be notified. Risk management documentation is done, and a note populates from the risk management documentation into the electronic medical record charting so everyone can see it. For pain control R1 received her already scheduled Tylenol; she did not receive anything else for pain. It was only when R1 moved that she complained of pain otherwise she was okay. This was a change for her; she is normally up in her wheelchair for meals and some activities. V9 stated she worked from 6:00 AM to 6:00 PM and then reported off to V17 LPN and told her that R1 had a stat x-ray ordered. V9 stated she told V17 what happened to R1 and that R1 was on bedrest until the x-ray results come back. V9 stated a stat x-ray is to be done within 4-6 hours from being ordered. V9 stated she didn't see R1 writhing in pain, or her leg turned out like normal with a hip fracture, so she just did what the doctor said.

On 12/1/23 at 11:48 AM, V1 RN (Registered Nurse/Regional Clinical Director) stated R1's medical record (paper and electronic) had very little documentation in it regarding the incident, so it is impossible to know what happened and piece it together. V1 stated she was not sure exactly how the mechanical lift flipped or what the cause was. V1 stated she found out later that an assessment was not done after R1's incident. V1 stated V3 LPN/Resident Care Coordinator told her that there wasn't any injury, but they were going to send R1 to the hospital for pain. V1 stated V10 LPN should have documented right away and not 4-5 days later because she wouldn't remember what happened later. V1 stated the A.I.M. (Assessment, Intercommunicate, &

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Management) Event Record should be filled out in the electronic medical record at the time of the incident/accident. V1 stated there should have been ongoing monitoring and documentation that ongoing monitoring of the resident is being done. V1 stated V10 did not notify R1's family and physician and she should have. V1 stated yes when asked if she felt neglect occurred for R1 after the incident on 11/21/23. V1 stated the nurse should have sent R1 to the hospital and didn't. V1 stated a lot more could have been done for R1. The stat x-ray should have been done in 4 hours. If staff couldn't get the x-ray done within 4 hours, then R1 should have been sent to the hospital. V1 stated if she had been the nurse, she would have sent R1 to the hospital after the fall as a standard precaution. R1 should have been sent to the hospital and had her pain treated. Everyone knew there was a fall, that she had pain and her scheduled Tylenol would not be effective for pain management. That shouldn't have happened.

On 12/1/23 at 1:03 PM, V10 LPN stated, on 11/21/23 at 5:30 AM V12 CNA came and got her because R1 was on the floor. V10 stated she went to R1's room, the floor was wet and R1 was in the mechanical lift sling on the floor crying and in pain. R1 was asking for her mom. V10 stated V12 told her the mechanical lift tipped over. V10 stated she told V12 that there was supposed to be 2 people for transfers with the mechanical lift. V12 stated to V10 that they always operate the mechanical lift by themselves and not with two people. V10 stated she was asked by V3 LPN/Resident Care Coordinator not to document that there was only 1 CNA for the transfer and to put that there were two CNA's. R1 couldn't tell her where her pain was located; just said that she had pain. V10 stated she gave R1 Tylenol and

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S9999	Continued From page 8 reported off to V10 LPN to do a follow up with R1 and V10 stated she would. V10 stated she told V9 what had happened. V10 stated she checked on R1 before she left and R1 was in pain. They dropped the ball on this and let R1 sit there for greater than 12 hours in pain and no stat x-ray done. There was no follow up. V10 stated after a fall or change in condition an assessment is done and documented. V10 stated she did not document at the time of the incident and came back in to document it. V10 stated she thought V9 would follow up and do an assessment for R1. V10 stated she did check R1's vital signs, did a body check but did not check range of motion. On 12/1/23 at 1:31 PM, V11 CNA stated she did not work the night when the lift tipped over on R1; V12 and V13 were working. V11 stated she was told by other staff that V12 and V13 were putting R1 to bed and the mechanical lift tipped over. V11 stated they are supposed to use 2 people when they do a transfer with a mechanical lift but there are a lot of girls that will do it by themselves. V11 stated she gets a lot of repercussions from other staff because she won't transfer a resident with a mechanical lift by herself and she gets told "you can do it yourself; we do it ourselves." V11 stated there is a mechanical lift with long legs on it and they have had to close the legs on the lift which then shifts it's balance. If they close the legs on the mechanical lift with the resident in it, then it swings, and the weight is not distributed evenly so it is not safe. On 12/1/23 at 2:00 PM, V12 CNA stated that her and V14 transferred R1 from the shower chair to the bed using a mechanical lift on 11/21/23 at 5:30 AM and the lift flipped. V12 stated R1 was not lifted above the shower chair, she pulled the shower chair out but R1's butt got stuck on the	S9999		

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shower chair, the lift flipped onto the right side. V12 stated the lift could have gotten caught under the chair and that they were not able to open the base (legs) of the mechanical lift all the way and that makes the lift unstable. V12 stated when you adjust the lift one way, the residents weight goes the opposite way, and the lift goes the other way and can flip.
V12 stated she got V10 LPN and the nurse came in and just looked at R1. She bent over and just looked at R1. The nurse did not palpate or check R1 for injuries. No vitals were done or range of motion. V10 assisted the CNAs to get R1 into bed. V12 stated in her opinion R1 should have been sent out; R1 had new pain. V12 stated she told V10 about the fall and told the oncoming CNA's what happened. V12 stated the day CNAs told her that night when she came back for her next shift that R1 had been in pain all day and they had told V9 about it. R1 sat like that too long. R1 was sent out the next day (11/22/23) on our shift at around 1:00 AM after they got the x-ray results. Every time we rolled R1 she complained of pain. Just laying in bed R1 looked fine, when moving she had pain.

On 12/5/23 at 11:00 AM, V13 CNA stated she worked with R1 on day shift after her fall. V13 stated they requested that we keep her in bed. V13 stated she didn't know anything happened until V9 came in and was talking about it, that it wasn't reported and to keep R1 in bed and not move her until she knew more about the pain. At first, we didn't reposition R1 or provide care. As the shift went on, we were trying to figure out a way to move and roll R1 without pain. We couldn't leave R1 like that. Maybe around 12:00 PM - 12:30 PM there was 3 CNA's and a nurse, and we had two people on each side. We tried to provide support to R1's hip with the most pain. R1

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was in pain so we tried to do this as quickly as possible. R1 was complaining of pain, scrunching her face and making noises when we were moving her. R1 slept a lot during the day. R1 was more vocal about pain with any movement.

On 12/5/23 at 11:43 AM V6 NA(Nursing Assistant) stated she worked on 11/21/23 from 6:00 AM to 2:00 PM and received report from V12 CNA who told her that the mechanical lift flipped and R1 fell. V6 stated V12 said R1 had pain and said she told V10 LPN the night nurse. R1 complained of pain that day but did not say what it was from. R1 stated her leg hurts, and her feet were tingling. R1 stated that on and off throughout the shift. R1 was in bed, and they told us to leave her in bed. V6 stated she asked V9 if there was anything they could do because R1 was in a lot of pain and V9 stated no and that R1 was fine, there was nothing we can do. V6 stated she couldn't just let R1 lay there in pain so around 12:00 PM - 1:00 PM she went to V2 DON and told her R1 was in pain. V2 was aware R1 was dropped in the mechanical lift but she was not aware of the severity of it. V6 stated she told V2 that R1 had pain and V2 had V6 call V9 LPN into the office. V2 told V9 to get an x-ray and give some Tylenol.

On 12/5/23 at 2:35 PM, V1 RN (Registered Nurse/Regional Clinical Director) stated the facility does not have a policy for nursing assessments after a fall/incident. V1 stated the nurses should assess after an incident, check range of motion, and a pain assessment should be done. This should be documented right away. V1 stated the nurses can put a health status note or do a follow up using the A.I.M record. V1 stated assessments should be done for 72 hours and should be done at least each shift. V1 stated

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S9999	Continued From page 11 that was not being done for R1. V1 stated this was just nursing 101 to do this. V1 stated R1 only received her scheduled Tylenol and did not have an order for as needed Tylenol. V1 stated if a nurse gave as needed Tylenol for R1, it's not documented in the electronic medical record. On 12/6/23 at 9:03 AM V16 (Physician) stated, it looks like on 11/21/23 at 2:47 PM I was notified of an incident with R1. I was notified the mechanical lift tipped in the shower and R1 had back and leg pain. I was told x-rays were ordered and I said that was fine. There was not a request for pain medication. With a fall of any kind, they should call right away, relay what happened and if the resident hits their head or not. If a resident is on blood thinners and hits their head, then they are sent to the emergency room 100% of the time. If not, and it depends on what has happened, we may opt for x-rays to be done. What happened was not good. The message I received did not have any urgency to it. After a fall, a nursing assessment should be done, and range of motion should be part of the assessment. The facility usually has a fall follow up protocol they follow. I would expect the facility to notify me if the available pain control they have is not effective. If the x-ray is not done in 4 hours and there is no sign of it being done, and the resident has pain then they should just send the resident to the hospital. When there is a fall, they should make sure the resident is safe, an assessment should be done, and I should be notified of the change in condition. It sounds like that wasn't done. I can't help if they don't notify me. On 12/6/23 at 9:35 AM, V1 RN (Registered Nurse/Regional Clinical Director) stated she found the AIM for Wellness Communication Form (A-Assess, I-Intercommunication, M-Manage)	S9999		

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S9999	Continued From page 12 policy that she thinks the facility uses as the policy for assessments after a fall/injury/change in condition. V1 RN (Regional Clinical Director) stated she did not have any competencies for the CNA's including competencies for mechanical lifts. V1 stated competencies should be done at hire and annually. On 12/6/23 at 10:41 AM, V14 CNA stated there were two of them for the transfer that night for R1. V14 stated the other girl (V12) called for help transferring R1 from the shower chair to the bed. V14 stated they used the tall white mechanical lift that gets tricky if it gets swinging it goes unbalanced. V14 stated the mechanical lift sling under R1 was wet and that got water on the floor. They were trying to get R1 to bed as soon as possible. V14 stated the mechanical lift began to swing in an unruly manner and it tipped over. V14 stated V12 was operating the lift. V14 stated she was standing there watching to see if the sling was still hooked. V14 stated it happened so fast, the sling started to swing, and the lift was tilting, and it was too hard to pull it back. V14 stated she was looking at the top of the lift and R1's butt could have gotten caught on the chair with the combination of the chair and floor being wet that could have caused the fall. V14 stated during a mechanical lift transfer one person operates the lift while the other person holds onto the sling and guides it. V14 stated if the sling gets caught when the lift is going up it can throw the lift off balance. V14 stated she wasn't doing anything with the sling lift under R1 because she wasn't out of the chair yet. V14 stated she thought maybe using a bigger shower chair for R1, so she wouldn't get stuck in the chair, would help with the transfers. V14 stated she has been doing mechanical lift transfers for 20 years and does not receive training yearly for competency on using a	S9999		

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S9999	Continued From page 13 mechanical lift. On 12/7/23 at 12:28 PM, V21 (R1's son/power of attorney) stated he still did not know exactly what happened and the facility won't tell him. V21 stated he was told the mechanical lift tipped and R1 fell. The facility told him the floor was slippery and the wheel got caught. V21 stated this is the second time "they broke her bones in a transfer. The last time they only had one person lifting her and should have had two people." V21 stated this happened about 1.5 years ago and R1's leg was broken during that transfer at the facility. V21 stated he did not know it happened at 5:30 AM because he wasn't notified about it until 3:30 PM. V21 stated he is upset that R21 did not have any pain medication and was probably in pain until she was seen at the second hospital. V21 stated the orthopedic doctor that did her surgery said it was an extremely painful break. V21 stated he is upset and worried about R1 at the facility. V21 stated R1 has dementia but knows who he is when they face time. V21 stated R1 is terrified she will be dropped. V21 stated he was not given a timeline on when this incident happened. V21 stated he told the facility he was not happy that he was not getting notified when things happen, or when R1 went to the hospital and when she returned. V21 stated, "It is incompetence at all levels. I continue to worry that she is in constant pain, and they can't get R1 back to where she was before they dropped her." On 12/7/23 at 1:02 PM, V5 CNA stated she worked day shift on 11/21/23 and was one of the CNA's that took care of R1. V5 stated V6 NA came to her and stated they have a problem and told her R1 had fallen in the mechanical lift, no one reported it, and R1 was complaining of pain and stating, "help me." V5 stated she told V9 LPN	S9999		

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S9999	Continued From page 14	S9999		

at 10:00 AM - 11:00 AM that R1 was complaining of pain, and V9 said, "I will figure it out" and walked away. V5 stated she never saw V9 check on R1. V5 stated V9 kept ignoring her and she got pissed. V5 stated she went to R1 and R1 was not the same; she was not okay. V5 stated at 1:30 PM - 2:00 PM she went to V2 DON and V2 had no clue what had happened or what was going on. V5 stated her and V6 told V2 they had heard R1 had fallen, she was screaming in pain and begging for help. V2 told them to get V9 who came to the office and V2 told her to give R1 pain medication and get a stat x-ray ordered.

The Diagnoses Report dated 12/5/23 for R1 showed diagnoses including cerebral infarction, hypertension, hypothyroidism, hyperlipidemia, major depressive disorder, dementia, age related osteoporosis, and obesity.

The November 2023 MAR (Medication Administration Record) for R1 showed she had an order for Acetaminophen 325 mg, give two tablets orally three times daily for pain at 8:00 AM, 12:00 PM, and 5:00 PM. R1 has had this order since 8/1/23. R1 received her scheduled doses of the medication on 11/21/23 and 11/22/23; no pain scale with administration was documented on the MAR.

The Minimum Data Set dated 10/10/23 for R1 showed total dependence for mobility and transfers.

As of 12/6/23 V12 CNA did not have any competencies/training by the facility for mechanical lifts. V14's last competency on the mechanical lift was dated 7/25/2007

The Care Plan dated 7/19/23 for R1 showed,

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S9999	Continued From page 15 Alteration in comfort/pain related to right foot drop. Administer analgesic as ordered and assess effectiveness. Monitor every shift for breakthrough pain. Evaluate residents' level of pain every shift and as needed. Ask "How would you rate your pain right now?" Monitor for indicators of pain. Interview for pain symptoms, causes and relief patterns. Use pain scale prior to administering pain medication and to evaluate effectiveness of pain medication. Utilize pain scale to assess intensity of pain (faces or 1-10 scale). Encourage the same type of scale each assessment to compare consistent values. The facility's Abuse Prevention Program (11/28/16) showed, Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Resident Protection Investigation Paths: Possible Neglect. Cause: Based on the allegation, determine what goods or services were not provided to the resident. Result: Determine what physical harm, mental anguish, mental illness, emotional distress or deterioration in the resident's physical or mental condition resulted in the failure to provide goods and services. Intent: Determine if the goods or services were not provided because of a pattern of deliberate negligence, carelessness, or indifference. The facility's AIM for Wellness Communication Form (A-Assess, I-Intercommunication, M-Manage) policy (10/23/18) showed, Policy: To communicate effectively between nurses and primary care providers the facility has developed standardized criteria. This form will be used on residents who have had a change in condition or for shift-to-shift communication among nursing	S9999		

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S9999	Continued From page 16 staff. Responsibility: Licensed nursing staff. Procedure: 1. Upon receiving a report in change of condition, review the resident's chart (diagnosis, medications, recent progress note from physician and nurses' notes). 2. Obtain an AIM for Wellness Form ...and talk with staff and/or family that is available about the current situation with the resident. 3. Refer to Care Paths or Acute Change in Status File Cards if indicated. 4. Complete every section of the AIM for Wellness Form prior to calling the medical doctor. 5. Have the chart available when making the call to the medical doctor. 6. Complete the AIM for Wellness Form and Progress Note. The Progress Note should be used to document the physical assessment, physician and POA (power of attorney) notification, treatment ordered and given, etc. 7. Place the AIM for Wellness Form and Progress Note in the Nurses Notes section of the medical record. 8. Use the AIM for Wellness Form to assist in shift report. The facility's Pain Prevention & Treatment Policy (12/7/17) showed it is the facility policy to assess for, reduce the incidence of and severity of pain in an effort to minimize further health problems, maximize ADL functioning and enhance quality of life. Assessment of pain will be completed with changes in the resident's condition, self-reporting of pain or evidence of behavioral cues indicative of the presence of pain and documented in the nurses notes or on the Pain Management Flow Sheet. This will include, but is not limited to, date, rating, treatment intervention and resident response. The Pain Management Flow Sheet will be initiated for those residents with but not limited to routine pain medication, daily pain, diagnosis that may anticipate pain (i.e., arthritis, wounds, fractures, etc.).	S9999		

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S9999	Continued From page 17 The facility's Notification for Change in Resident Condition or Status policy (12/7/17) showed the facility and/or facility staff shall promptly notify appropriate individuals (i.e., Administrator, DON, Physician, Guardian, HCPOA - Healthcare Power of Attorney, etc.) of changes in the resident's medical/mental condition and/or status. 1. The nurse supervisor/charge nurse will notify the resident's attending physician or on-call physician when there has been: a. Any symptom, sign or apparent discomfort is: 1. Sudden onset; 2. A marked change (i.e., more severe) in relation to usual signs or symptoms; 3. Unrelieved by measures already prescribed. b. An accident or incident involving the resident; h. A need to transfer the resident to a hospital/treatment center. 2. The nurse supervisor/charge nurse will notify the DON, physician, and unless otherwise instructed by the resident the resident's next of kin or representative when the resident has any of the afore mentioned situations or: a. The resident is involved in any accident or incident that results in an injury including injuries of unknown source; b. There is a significant change in the resident's physical, mental, or psychological status. 3. Except in medical emergencies, notification will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status. The facility's Safe Resident Handling and Movement policy (no date) showed, the facility wants to ensure that it's residents are cared for safely, while maintaining a safe work environment for employees. This infrastructure includes resident handling and movement equipment, employee training, and a "Culture of Safety" approach to safety in the work environment. Goals: Reduce injury potential for both resident and caregiver. Assure staff competency in the safe use of transfer and mobility related	S9999		

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S9999	Continued From page 18 equipment. Procedures: It is the duty of employees to take reasonable care of their own health and safety, as well as that of their co-workers and their residents during handling activities by following this policy. Use mechanical lift devices and other approved resident handling aids in accordance with instructions and training. Staff will complete and document safe resident handling and movement equipment training initially, annually, and as required to correct improper use/understanding of safe resident handling and movement. Nursing Management: Ensure high-risk resident handling tasks are assessed periodically and staff are completing the tasks safely, using mechanical lifting devices and other approved resident handling aids and appropriate techniques. (A) 2 of 3 300.510a) 300.510c) 300.610a) 300.650f)1) 300.650f)2) 300.820a) 300.1010h) 300.1210b) 300.1210d)3) 300.1210d)6) 300.3240a) Section 300.510 Administrator a) There shall be an administrator licensed under the Nursing Home Administrators Licensing and Disciplinary Act (Ill. Rev. Stat. 1987, ch. 111,	S9999		

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S9999	Continued From page 19 par. 3651 et seq.) full-time for each licensed facility. The licensee will report any change in administrator to the Department, within five days. c) The administrator shall arrange for facility supervisory personnel to annually attend appropriate educational programs on supervision, nutrition, and other pertinent subjects. 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 300.650 Personnel Policies f) Orientation and In-Service Training 1) All new employees, including student interns, shall complete an orientation program covering, at a minimum, the following: general facility and resident orientation; job orientation, emphasizing allowable duties of the new employee; resident safety, including fire and disaster, emergency care and basic resident safety; infection prevention and control; and understanding and communicating with the type of residents being cared for in the facility. In addition, all new direct care staff, including	S9999		

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S9999	Continued From page 20 student interns, shall complete an orientation program covering the facility's policies and procedures for resident care services before being assigned to provide direct care to residents. This orientation program shall include information on the prevention and treatment of decubitus ulcers and the importance of nutrition in general health care. 2) All employees, except student interns shall attend in-service training programs pertaining to their assigned duties at least annually. These in-service training programs shall include the facility's policies, including infection prevention and control policies required in Section 300.696, skill training and ongoing education to enable all personnel to perform their duties effectively. The in-service training sessions regarding personal care, nursing and restorative services shall include information on the prevention and treatment of decubitus ulcers. In-service training concerning dietary services shall include information on the effects of diet in treatment of various diseases or medical conditions and the importance of laboratory test results in determining therapeutic diets. Written records of program content for each session and of personnel attending each session shall be kept. Section 300.820 Categories of Personnel a) The facility shall provide an administrator as set forth in Subpart B. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the	S9999		

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S9999	Continued From page 21 health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. (B) 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 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	S9999		

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S9999	Continued From page 22 and assistance to prevent accidents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) Based on observation, interview, and record review the facility failed to have a full time Administrator at the facility which contributed to deficient practices in the facility. This failure resulted in residents not receiving necessary care and services including nursing assessments, pain assessments, and pain documentation. The facility failed to follow their own policies and procedures and failed to ensure staff were trained upon hire and annually on the use of facility equipment. This has the potential to affect all 31 residents in the facility. The findings include: The Facility Data Sheet dated 12/1/23 showed the facility had a census of 31 residents. On 12/1/23 upon entry to the facility they did not have an Administrator and the Corporate Administrator overseeing the building was not onsite. On 12/1/23 at 9:15 AM, V2 DON (Interim Director of Nursing) stated the facility has not had an Administrator for 2-3 weeks. V2 stated V22 (Corporate Administrator) was over the building. V2 stated the DON was moved to another facility 1 week ago. V2 stated she is acting DON but is also the MDS/Care Plan Coordinator. V3 LPN (Licensed Practical Nurse) stated she is the Resident Care Coordinator. V2 stated recently R1 was injured during an unsafe transfer. V2 stated the mechanical lift tipped over during a transfer	S9999		

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S9999	Continued From page 23 and R1 fell. V2 stated they found out 20 hours later that R1 had a hip fracture. V2 stated she was never informed of the accident for R1 that occurred on 11/21/23 at 5:30 AM until 11/21/23 at 2:30 PM when it was brought to her attention by some CNA's (Certified Nursing Assistants). V2 and V3 stated V10 LPN (Licensed Practical Nurse/night nurse) did not do any assessment after the incident; V10 did not document anything. V2 stated V10 was on shift on 11/21/23 until 6:00 AM. V2 stated she expected a head-to-toe assessment to be completed and documented after the incident. V2 stated V10 told her R1 complained of pain, she gave R1 Tylenol, and she reported what happened to V9 LPN (the oncoming day nurse). V2 stated when she asked V9 the nurse told her that when she talked to R1 she wasn't having any pain. V9 never documented an assessment or pain assessment for R1. V2 and V3 stated nurses are to document assessments and if they are not documented then they are not done. V3 stated if they could have done anything differently, they would have provided pain control for R1; that was her biggest concern for R1. V3 stated the scheduled Tylenol that R1 had was not enough. V2 stated R1 suffered in pain on 11/21/23 and 11/22/23 until R1 received pain medication on the evening of 11/22/23. V2 stated R1 was in pain for 24 hours. V2 and V3 stated V10 came in 4-5 days later and entered a late entry for R1 for the incident that occurred on 11/21/23 at 5:30 AM. On 12/1/23 at 11:48 AM, V1 (Corporate Regional Nurse) was advised by IDPH (Illinois Department of Public Health) of the seriousness of the concerns. IDPH was onsite at the facility on 12/5/23, 12/7/23 and 12/8/23 and V22 (Corporate Administrator) was not onsite.	S9999		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 24 On 12/7/23 at 11:23 AM, an IJ - Immediate Jeopardy was declared at the facility for deficient practices in the facility. The IJ was declared with V2 (acting DON). V1 (Corporate Regional Nurse) and V22 (Corporate Administrator) were not at the facility. On 12/7/23 at 12:15 PM, V2 said the last Administrator left around 11/18/23 to another facility, and at times will assist with some Administrative duties. She said V1 is not in the facility even weekly, maybe 3-5 times a month. The Corporate Administrator is physically not in the facility but may do some parts of the job. On 12/7/23 at 3:30 PM, V1 was at the facility and stated the facility doesn't have an Administrator and the Corporate Administrator was not onsite. V1 stated she knew the facility was supposed to have a full time Administrator in the building. V1 stated she did not know how often the Corporate Administrator comes to the facility. The facility's Job Description Administrator (no date) showed, job summary - The Administrator is responsible for managing, planning, organizing, staffing, directing, coordinating, reporting, budgeting and physical management of the facility, residents & equipment in a way that the purpose of the facility shall be maintained in accordance with all established practices, policies, laws, and applicable state regulations. The Administrator will manage and conduct business of the facility in a manner that protects the facility license and certification at all times. The major goal of the Administrator is to provide an atmosphere in which residents may achieve their highest physical, mental and social wellbeing.	S9999		

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S9999	Continued From page 25 A review of R1's medical records showed she did not receive necessary care and services including nursing assessments, pain assessments and pain documentation from 11/21/23 at 5:30 AM through 11/22/23 at 1:25 AM (approximately 20 hours) when R1 was transported to the emergency department for evaluation and treatment of a right hip fracture. The A.I.M. (Assessment, Intercommunicate, & Management) Event Record Late Entry for R1 for the incident on 11/21/23 at 5:30 AM showed there were two CNA's present, the mechanical lift tipped, and the resident fell. R1 was being transferred from the "shower to bed," and had a new onset of pain. The physician, the resident's responsible party and facility management were not notified at the time of the incident. It happened around shift change so the nurse endorsed to the oncoming nurse to follow up. There weren't any other nursing assessments or pain assessments completed for R1 on 11/21/23. On 12/1/23 at 11:48 AM, V1 RN (Registered Nurse/Regional Clinical Director) stated R1's medical record (paper and electronic) had very little documentation in it regarding the incident, so it is impossible to know what happened and piece it together. V1 stated she was not sure exactly how the mechanical lift flipped or what the cause was. V1 stated she found out later that an assessment was not done after R1's incident. V1 stated V10 LPN should have documented right away and not 4-5 days later because she wouldn't remember what happened later. V1 stated the A.I.M. (Assessment, Intercommunicate, & Management) Event Record should be filled out in the electronic medical record at the time of the incident/accident. V1 stated there should have been ongoing monitoring and documentation that ongoing monitoring of the resident is being done.	S9999		

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S9999	Continued From page 26 V1 stated V10 did not notify R1's family and physician and she should have. V1 stated yes when asked if she felt neglect occurred for R1 after the incident on 11/21/23. V1 stated the nurse should have sent R1 to the hospital and didn't. V1 stated a lot more could have been done for R1. R1 should have been sent to the hospital and had her pain treated. Everyone knew there was a fall, that she had pain and her scheduled Tylenol would not be effective for pain management. That shouldn't have happened. On 12/6/23 at 9:03 AM V16 (Physician) stated, it looks like on 11/21/23 at 2:47 PM I was notified of an incident with R1. What happened was not good. The message I received did not have any urgency to it. After a fall a nursing assessment should be done and range of motion should be part of the assessment. The facility usually has a fall follow up protocol they follow. I would expect the facility to notify me if the available pain control they have is not effective. If the x-ray is not done in 4 hours and there is no sign of it being done, and the resident has pain then they should just send the resident to the hospital. When there is a fall, they should make sure the resident is safe, an assessment should be done, and I should be notified of the change in condition. It sounds like that wasn't done. I can't help if they don't notify me. The facility failed to follow the following policies: A. The facility's Abuse Prevention Program (11/28/16) showed, Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Resident Protection Investigation Paths: Possible Neglect.	S9999		

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S9999	Continued From page 27 Cause: Based on the allegation, determine what goods or services were not provided to the resident. Result: Determine what physical harm, mental anguish, mental illness, emotional distress or deterioration in the resident's physical or mental condition resulted in the failure to provide goods and services. Intent: Determine if the goods or services were not provided because of a pattern of deliberate negligence, carelessness, or indifference. B. The facility's AIM for Wellness Communication Form (A-Assess, I-Intercommunication, M-Manage) policy (10/23/18) showed, Policy: To communicate effectively between nurses and primary care providers the facility has developed standardized criteria. This form will be used on residents who have had a change in condition or for shift-to-shift communication among nursing staff. Responsibility: Licensed nursing staff. Procedure: 1. Upon receiving a report in change of condition, review the resident's chart (diagnosis, medications, recent progress note from physician and nurses' notes). 2. Obtain an AIM for Wellness Form ...and talk with staff and/or family that is available about the current situation with the resident. 3. Refer to Care Paths or Acute Change in Status File Cards if indicated. 4. Complete every section of the AIM for Wellness Form prior to calling the medical doctor. 5. Have the chart available when making the call to the medical doctor. 6. Complete the AIM for Wellness Form and Progress Note. The Progress Note should be used to document the physical assessment, physician and POA (power of attorney) notification, treatment ordered and given, etc. 7. Place the AIM for Wellness Form and Progress Note in the Nurses Notes section of the medical record. 8. Use the AIM for Wellness Form to assist in shift report.	S9999		

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S9999	Continued From page 28 C. The facility's Pain Prevention & Treatment Policy (12/7/17) showed it is the facility policy to assess for, reduce the incidence of and severity of pain in an effort to minimize further health problems, maximize ADL functioning and enhance quality of life. Assessment of pain will be completed with changes in the resident's condition, self-reporting of pain or evidence of behavioral cues indicative of the presence of pain and documented in the nurses notes or on the Pain Management Flow Sheet. This will include, but is not limited to, date, rating, treatment intervention and resident response. The Pain Management Flow Sheet will be initiated for those residents with but not limited to routine pain medication, daily pain, diagnosis that may anticipate pain (i.e., arthritis, wounds, fractures, etc.). D. The facility's Notification for Change in Resident Condition or Status policy (12/7/17) showed The facility and/or facility staff shall promptly notify appropriate individuals (i.e., Administrator, DON, Physician, Guardian, HCPOA - Healthcare Power of Attorney, etc.) of changes in the resident's medical/mental condition and/or status. 1. The nurse supervisor/charge nurse will notify the resident's attending physician or on-call physician when there has been: a. Any symptom, sign or apparent discomfort is: 1. Sudden onset; 2. A marked change (i.e., more severe) in relation to usual signs or symptoms; 3. Unrelieved by measures already prescribed. b. An accident or incident involving the resident; h. A need to transfer the resident to a hospital/treatment center. 2.The nurse supervisor/charge nurse will notify the DON, physician, and unless otherwise instructed by the resident the resident's next of	S9999		

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S9999	Continued From page 29 kin or representative when the resident has any of the afore mentioned situations or: a. The resident is involved in any accident or incident that results in an injury including injuries of unknown source; b. There is a significant change in the resident's physical, mental, or psychological status. 3. Except in medical emergencies, notification will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status. E. The facility's Safe Resident Handling and Movement policy (no date) showed, the facility wants to ensure that it's residents are cared for safely, while maintaining a safe work environment for employees. This infrastructure includes resident handling and movement equipment, employee training, and a "Culture of Safety" approach to safety in the work environment. Goals: Reduce injury potential for both resident and caregiver. Assure staff competency in the safe use of transfer and mobility related equipment. Procedures: It is the duty of employees to take reasonable care of their own health and safety, as well as that of their co-workers and their residents during handling activities by following this policy. Use mechanical lift devices and other approved resident handling aids in accordance with instructions and training. Staff will complete and document safe resident handling and movement equipment training initially, annually, and as required to correct improper use/understanding of safe resident handling and movement. Nursing Management: Ensure high-risk resident handling tasks are assessed periodically and staff are completing the tasks safely, using mechanical lifting devices and other approved resident handling aids and appropriate techniques.	S9999		

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S9999	Continued From page 30 The facility failed to ensure staff were trained on mechanical lifts devices upon hire and at yearly competencies. During the survey from 12/1/23 through 12/8/23 the facility could not state when the last time they had any competencies done with staff and could not find any paperwork in at least the last 5 years. On 12/6/23 at 9:35 AM, V1 RN (Regional Clinical Director) stated she did not have any competencies for the CNA's including competencies for mechanical lifts. V1 stated competencies should be done at hire and annually. On 12/7/23 at 12:15 PM, V2 said she does not have records for competencies and training, she would have to request them from corporate. A copy of the facility assessment was requested, and V2 said she did not know what a facility assessment was. On 12/7/23 at 1:00 PM, V5 CNA said she had been employed for one year in the facility, and during that time she has not had to perform any demonstrations for evaluation. She said there have not been any annual evaluations. On 12/7/23 at 1:02 PM, V20 CNA said she had been working at the facility since July. When she was hired no one reviewed the mechanical lift training with her, and she had no supervisors observe her performing transfers. V20 said for trainings she is given materials to read, usually by whoever the DON is at the time. On 12/7/23 at 1:10 PM, V18 CNA said she started 4 months ago and recalls in-services on fire, falls, and safety. Upon hire she was given material and talked about mechanical lift transfers, but the	S9999		

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S9999	Continued From page 31 DON had not observed her perform any transfers. She said there has not been any skills checks since she has been at the facility. On 12/7/23 at 1:13 PM, V8 CNA said she had been working in the facility for 5 years. She said the last training she had regarding the mechanical lift was in school. She has had no annual skills test with observations and return demonstrations. (B) 3 of 3 300.690)c) Section 300.690 Incidents and Accidents c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. This requirement is not met as evidenced by:	S9999		

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S9999	Continued From page 32 Based on interview and record review the facility failed to ensure the IDPH (Illinois Department of Public Health) regional office was notified within 24 hours after R1's incident/accident. The facility failed to ensure an accurate narrative summary of the reportable accident/incident was reported. This applies to one of three residents (R1) reviewed for incidents and accidents in the sample of 5. The findings include: The facility's Initial Report to IDPH (Illinois Department of Public Health) showed it was dated and sent on 11/22/23 at 1:53 PM. The report showed the date of the incident was on 11/21/23 but did not state what time it occurred. The report showed the resident sustained a ground level witnessed fall. Resident was immediately assessed and sent out to the hospital for further evaluation. The report showed the physician and POA were notified. This was the initial report, and a 5-day report would follow. The facility's Final Report dated 11/28/23 to Illinois Department of Public Health for R1's Incident on 11/21/23 showed, R1 sustained a ground level witnessed fall. Resident was immediately assessed by the nurse and sent to the hospital for further evaluation. R1 was diagnosed with a greater trochanteric fracture; surgical repair was noted to be not operative at this time per medical doctor. R1 returned to the facility with new interventions and pain management in place. Further consult was obtained; surgical repair was completed on 11/25/23. R1 is currently at the hospital and plans to return to the facility upon discharge. This is our final report. Signed by V1 - Regional Clinical	S9999		

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S9999	Continued From page 33 Director. The report did not show that the resident was injured during a mechanical lift transfer, nursing assessments were not done right away or ongoing. On 12/1/23 at 9:15 AM, V2 DON (Director of Nursing) stated she is the current acting DON. V3 LPN (Licensed Practical Nurse) stated she is the resident care coordinator. V2 stated R1 was recently injured during an unsafe mechanical lift transfer. V2 stated they ultimately found out the floor was wet, and the mechanical lift fell over with R1 in the lift. V2 stated they found out about 20 hours later that R1 had a greater trochanter fracture (right hip fracture). V2 stated she found out on 11/21/23 at 2:30 PM by V5 CNA (Certified Nursing Assistant) and V6 CNA that R1 complained of back pain and was not feeling well. V2 stated she asked V5 and V6 if V9 (Licensed Practical Nurse) was told and they stated, "yes" and that R1 had been hurt during a fall that morning. V9 stated she knew R1 had a fall. V2 stated she texted V16 (Physician) at 2:47 PM and told him R1 had a fall and asked him for x-ray orders. V2 and V3 stated they did not take the legs off R1's wheelchair and that was part of the reason the mechanical lift tipped when they were maneuvering the lift around the legs and the floor being wet. V12 and V14 went to get V10 (LPN) after the fall. V12 stated V10 was asleep at the nurse's desk and would not know if 1 CNA did the transfer. V2 and V3 stated the CNAs should have removed the foot pedals and the mechanical lift they uses gets stuck under the wheelchair due to the foot pedals. It affects the center of gravity and the mechanical lift tipped. It was an unsafe transfer and unsafe environment. V2 stated V1 RN (Registered Nurse/Regional Clinical Director) was responsible for submitting the report to IDPH. V2 stated she didn't submit anything to IDPH	S9999		

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S9999	Continued From page 34 about R1's incident. V3 stated abuse reporting must be done immediately or within 2 hours to the state. V3 stated they have 24 hours to report to the state from the time the incident happens and this incident happened on 11/21/23 at 5:30 AM. On 12/1/23 at 11:48 AM, V1 RN (Registered Nurse/Regional Clinical Director) stated R1's medical record (paper and electronic) had very little documentation in it regarding the incident, so it is impossible to know what happened and piece it together. V1 stated she was not sure exactly how the mechanical lift flipped or what the cause was. V1 stated she gets the information for the incident from the facility, she types it up and then gives it to V2 and V3 and they will send it to IDPH. V1 stated she reported the incident to IDPH when the x-ray results came back and she knew R1 had a fracture. V1 stated IDPH should be notified of the incident within 24 hours from when it happened. On 12/6/23 at 9:03 AM V16 (Physician) stated, it looks like on 11/21/23 at 2:47 PM I was notified of an incident with R1. I was notified the mechanical lift tipped in the shower and R1 had back and leg pain. I was told x-rays were ordered and I said that was fine. There was not a request for pain medication. With a fall of any kind, they should call right away, relay what happened and if the resident hits their head or not. If a resident is on blood thinners and hits their head, then they are sent to the emergency room 100% of the time. If not, and it depends on what has happened we may opt for x-rays to be done. What happened was not good. The message I received did not have any urgency to it. When there is a fall, they should make sure the resident is safe, an assessment should be done, and I should be notified of the change in condition. It sounds like	S9999		

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S9999	Continued From page 35 that wasn't done. I can't help if they don't notify me. On 11/7/23 at 12:28 PM, V21 (R1's son/power of attorney) stated he still did not know exactly what happened and the facility won't tell him. V21 stated he was told the mechanical lift tipped and R1 fell. The facility told him the floor was slippery and the wheel got caught. V21 stated this is the second time "they broke her bones in a transfer. The last time they only had one person lifting her and should have had two people." V21 stated this happened about 1.5 years ago and R1's leg was broken during that transfer at the facility. V21 stated he did not know it happened at 5:30 AM because he wasn't notified about it until 3:30 PM. V21 stated he is upset that R21 did not have any pain medication and was probably in pain until she was seen at the second hospital. V21 stated the orthopedic doctor that did her surgery said it was an extremely painful break. V21 stated he is upset and worried about R1 at the facility. V21 stated R1 has dementia but knows who he is when they face time. V21 stated R1 is terrified she will be dropped. V21 stated he was not given a timeline on when this incident happened. V21 stated he told the facility he was not happy that he was not getting notified when things happen, or when R1 went to the hospital and when she returned. V21 stated, "It is incompetence at all levels. I continue to worry her even now so she is not in constant pain, and they can get R1 back to where she was before they dropped her." The facility's Notification for Change in Resident Condition or Status policy (12/7/17) showed the facility and/or facility staff shall promptly notify appropriate individuals (i.e., Administrator, DON, Physician, Guardian, HCPOA - Healthcare Power of Attorney, etc.) of changes in the resident's	S9999		

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S9999	Continued From page 36 medical/mental condition and/or status. 1. The nurse supervisor/charge nurse will notify the resident's attending physician or on-call physician when there has been: a. Any symptom, sign or apparent discomfort is: 1. Sudden onset; 2. A marked change (i.e. more severe) in relation to usual signs or symptoms; 3. Unrelieved by measures already prescribed. b. An accident or incident involving the resident; h. A need to transfer the resident to a hospital/treatment center. 2.The nurse supervisor/charge nurse will notify the DON, physician, and unless otherwise instructed by the resident the resident's next of kin or representative when the resident has any of the afore mentioned situations or: a. The resident is involved in any accident or incident that results in an injury including injuries of unknown source, b. There is a significant change in the resident's physical, mental, or psychological status. 3. Except in medical emergencies, notification will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status. The facility's policy did not state when the facility would report to IDPH. No other policies for reporting to IDPH were available from the facility from 12/1/23 through exit on 12/8/23. (C)	S9999		