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	IL6016356	A. BUILDING: _____ B. WING _____	C 08/09/2024

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S 000	Initial Comments Complaint Investigation: 2416207/IL176417	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b)4)5) 300.1210d)3)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 300.1010 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, 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.	S9999		

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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.

4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

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

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S9999	Continued From page 2 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. This REQUIREMENT is not met as evidenced by: A. Based on interview and record review the facility failed to safely transfer a resident using a mechanical lift. This failure resulted on R1 sustaining a femur fracture requiring surgery. This applies to one of three residents reviewed for safety in the sample of three. B. Based on interview and record review the facility failed to ensure a resident (R1) was assessed in a timely manner after being lowered to the ground during a mechanical lift transfer on 7/26/24 at 5:30 AM which resulted in a left hip fracture. The facility failed to notify the physician in a timely manner and provide ongoing nursing assessments from the time of the incident on 7/26/24 at 5:30 AM through 8/1/24 when R1 was transported to the emergency department for evaluation and treatment of a left hip fracture. These failures resulted in R1 not receiving required medical evaluations and treatment after being lowered to the ground when she was falling from a mechanical lift on 7/26/24. This applies to one of three residents (R1) reviewed for injury in the sample of three.	S9999		

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The findings include:

The facility face sheet for R1 shows diagnoses to include fibromyalgia, Atrial Fibrillation, congestive heart failure and dementia. The facility assessment dated 7/14/2024 shows R1 to have severe cognitive impairment and required maximum staff assistance with bed mobility and transfers.

The final report dated 7/31/24 for a bruise of unknown origin shows upon further investigation it was discovered that the resident was being transferred by a sit to stand lift for a shower. During the transfer, R1 became agitated and began to come out of the sit to stand sling. The report shows this staff lowered the resident to the floor. The sling caused pressure to the left shoulder which developed into a bruise. An additional follow-up, post 5-day summary dated 8/2/24 shows R1 was noted with bruising to her left lower extremity and had an increase in pain. An x-ray revealed a fracture to the left distal femur.

On 8/7/24 at 12:55 PM, V1 (Administrator) said for the resident's safety during a mechanical lift transfer, there must be two staff present.

On 8/7/24 at 3:00 PM, V5 (Certified Nursing Assistant/CNA) said he was the CNA caring for R1 on Friday 7/26/24. V5 said he was to give R1 a shower that morning. V5 said the shower began around 5:30 AM. After the shower was completed and he was preparing to transfer R1, she became agitated and resistive to having the lift sling placed under her arms. V5 said he proceeded with the transfer anyway and as the transfer was happening, she began to slide out of

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the lift sling. V5 said her legs were standing on the base of the lift and she never fell to the floor. V5 said he was alone during the transfer and knows he was to have assistance with the transfer. V5 said he did not report the incident to the nurse because R1 did not get hurt and he didn't feel he had to. V5 said R1 was lowered to the ground and a sling for the mechanical lift was placed under R1 as she lay on the floor, and she was lifted up off the floor into her wheelchair.

On 8/7/24 at 6:39 PM, V6 (CNA) said on the morning of 7/26/24, at around 5:30 AM, she heard yelling from the shower room and noticed the door was ajar. V6 said when R1 gets a shower, she does yell out loudly. V6 said she wanted to close the door to avoid disrupting the other residents in the unit. V6 said she peeked in the room and saw R1 hanging from the sit to stand lift sling with her arms raised high and her legs dangling near the ground. V6 said R1 was not bearing any weight on her legs at the time. V6 said V5 (CNA) was just standing there looking at R1 with a shocked look on his face. V6 said V5 was not doing anything to help R1. V6 said she immediately went into the room, told V5 to grab R1 from behind and support her weight and V6 lowered the lift arm and detached the arm sling from R1 and V5 lowered R1 to the ground. V6 said V5 did not have the leg band secured around R1's legs. V6 said she went and got the mechanical lift and together her and V5 rolled R1 onto a sling and lifted her off the floor and into her wheelchair. V6 said she knew the incident should have been reported to the nurse and she assumed V5 would do that.

On 8/8/24 at 9:45 AM, V3 (Director of Nursing) said a bruise of unknown origin was reported to

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her on 7/27/24 to R1's left shoulder. V3 said an investigation was started and it was discovered R1 was lowered to the ground on 7/26/24 in the shower room. V3 said bruising and resident complaints of pain were to her left shoulder only, until on 8/1/24 when bruising and limited range of motion was observed for R1. An x-ray revealed a fracture to R1's left femur. V3 said R1 was not complaining of any pain to her leg in the week between the incident and when the fracture was identified. V3 said she expects staff to have two CNAs present for all transfers involving a mechanical lift. V3 said this is for the safety of the resident. One staff to run the lift and another staff to guide and protect the resident. V3 said the staff should have gotten the nurse before moving the resident so an assessment could have been completed to check for injuries.

On 8/8/24 at 2:13 PM, V10 (Advanced Practice Nurse) said when R1 was lowered to the ground on 7/26/24, it should have been reported to the nurse right away so an assessment for injuries could have been performed. V10 said she expects the staff to perform an assessment to check for any acute injuries and the resident should be closely monitored for at least 24 hours after an incident.

On 8/8/24 at 5:27 PM, V13 (Orthopedic Surgeon) said R1 had very poor bone quality so being lowered to the ground during a transfer could have led to this type of fracture. V13 said R1 had a bad injury, and she should have been sent out to the emergency department after the incident for x-rays and treatment.

The x-ray report dated 8/2/24 (seven days after the incident of being lowered to the ground)

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shows R1 had a fracture of the distal shaft (lower) of the left femur (thigh bone) with some overriding of the fracture fragments.

The nursing progress note dated 8/1/24 at 12:55 AM, shows R1 was experiencing restricted range of motion to her lower extremities. R1 would scream in pain when leg was moved, substantial swelling to the entire leg and R1 not able to tolerate leg extension, flexion, or elevation. On the same day at 7:46 AM, it was documented in R1's records that R1 now had discoloration on the back of her leg and back of the knee.

The hospital emergency department report dated 8/2/24 shows R1 had a fall reportedly one week ago and the details of the fall were unknown. R1's left leg was swollen with tenderness and bruising noted to the back of the leg and painful range of motion. The x-ray of the left leg showed a closed fracture of the distal end of the left femur.

The hospital progress note dated 8/2/24 completed by the Orthopedic surgeon showed the left lower is shortened and R1 grimaces when the leg was palpated.

The undated facility final conclusion for bruise and fracture of unknown origin, upon completion of investigation shows it is believed that the left femur fracture is related to the reported incident of resident being lowered to the ground by staff on 7/26/24.

The facility policy with a revision date of March 2024 for lifting machine, using a mechanical lift shows at least two nursing assistants or nurse are needed to safely move a resident with a mechanical lift.

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S9999	Continued From page 7 The facility falls clinical protocol assessment and recognition revised March 2018 shows the nurse shall assess and document/report the following: vital signs, recent injury, observe for change in normal range of motion, weight bearing, change in cognition or level of consciousness, neurological status, pain, precipitating factors, details on how the fall occurred... "A"	S9999		