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BIG MEADOWS	1000 LONGMOOR SAVANNA, IL 61074

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S 000	Initial Comments Investigation of Facility Reported Incident of February 13, 2024/IL170125	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b)4)5) 300.1210d)1)2)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 300.1210 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	S9999		

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S9999	Continued From page 1 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 2) All treatments and procedures shall be administered as ordered by the physician. 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 This REQUIREMENT is not met as evidenced by: A. Based on observation, interview, and record review the facility failed to transport a resident in a wheelchair with her feet on the foot pedals. This failure resulted in R1 sustaining a fracture to her right femur. This applies to 1 of 3 residents (R1) reviewed for safety in the sample of 3. B. Based on observation, interview, and record review the facility failed to manage a resident's (R1) pain when she was known to have a fractured leg and she was transferred without her immobilizer. The facility also failed to provide pain medication for resident (R1) with fractured leg prior to transferring her out of bed. This failure resulted in R1 experiencing excruciating pain. This applies to 1 of 3 residents reviewed for pain in the sample of 3. The findings include: R1's Admission Record (Face Sheet) showed an original admission date of 11/1/23 with diagnoses to include: cervical vertebra fracture (bones in the neck, was her admitting diagnosis), osteoporosis (decreased bone strength) without current pathological fracture (no fractures due to her osteoporosis), arthritis, cognitive communication deficit, lack of coordination, difficulty in walking, lack of coordination, need for assistance with personal care, and adult failure to thrive. The facility's final incident report submitted on 2/14/24 showed "...it appears that [R1] moved her foot from the foot pedal while being assisted from the dining room causing her foot to touch the	S9999		

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floor. The staff member stopped immediately when this happened and called the nurse stat." The report showed an x-ray was ordered and she sustained a nondisplaced, periprosthetic distal femoral fracture (fracture of the thigh bone near the knee and around her knee replacement hardware).

On 2/22/24 at 12:30 PM, V1 (Administrator) stated the facility's recorded video footage from 2/13/24 was fast by 15 to 20 minutes.

On 2/22/24 at 12:07 PM, recorded video footage from the "Main Dining Room" camera was reviewed. The footage showed on 2/13/24 at 6:17 PM, R1 was seated at a dining table with two other residents. R1 was seated at a dining table near the dining room door with her right side facing the door and her left side facing the camera. V11 (Dietary Aide) approached R1, unlocked R1's wheelchair, pulled her away from the table and took her out of the dining room. R1 had a blanket covering her lower half, which extended to cover most of her feet and the foot pedals. Also, R1's feet were not visible under the dining table. V11 did not stop and adjust R1's feet or have R1 adjust her own feet after she pulled R1 away from the table. V11 did not pull back R1's blanket to fully expose the foot pedals or R1's feet.

On 2/22/24 at 12:22 PM, recorded video footage from the "Lobby Front" cameral was reviewed. The video footage from 2/13/24 showed a close view of the dining room entrance and the front lobby entrance. R1's dining table was just visible. As V11 pushed R1 out of the dining room doors (10 feet at most from her dining table), the toes of

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S9999	Continued From page 4 R1's right foot is visible, most of her left foot is visible, and the front edge of the foot pedals are visible. The soles of R1's feet are not on the pedals. R1's feet are in between the foot pedals. The right side of R1's right ankle is resting on the right foot pedal. Most of R1's right foot is below the foot pedal. On 2/22/24 at 11:54 AM, recorded video footage from the "Multi Room 2" camera was reviewed at one quarter speed and was viewed several times. The video from 2/13/24 at 6:17 PM showed the hallway leading from the main entrance/dining room area to the resident hallways; however, the dining room and main entry were not visible. The video showed V11 pushing R1 in her wheelchair down the hallway. At approximately 20 feet from the dining room door, R1's foot touched the floor; her leg raised up as her foot started to go behind and under her; R1's upper body lunged forward; V11 grabbed R1's left shoulder and pulled her back into the wheelchair; V11 stopped the wheelchair; and pulled the wheelchair backwards 1 to 2 feet. During this incident, there was no indication R1 lifted her leg off the pedal; the only movement of her leg was straight down to the floor then her knee raised up after her foot touched the floor. V11 then got on her radio and R1 pulled the blanket off her right leg. R1's right leg and foot were under the seat of the wheelchair. Nursing staff arrived, placed R1's foot on the pedal, and pushed R1 down the hallway and out of view of the camera. On 2/22/24 at 12:30 PM, V1 stated, while viewing a still image of the Lobby Front video footage, she agreed, the soles of R1's feet were not firmly planted on the foot pedals of the wheelchair. On 2/22/24 at 3:10 PM, V11 (Dietary Aide) stated	S9999		

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she was allowed to push residents in wheelchairs if the resident had foot pedals. V11 stated she was educated the residents feet needed to be on the foot pedals. V11 stated R1's feet were on the foot pedals the evening of 2/13/24. V11 stated as she pushed R1 down the hallway, "... I saw her lift her leg, I slowed down, her leg dropped, she said 'Ow', I stopped, and I called the nurses. V11 stated she did not have to tell R1 to put her feet on the foot pedals because they were already on the foot pedals. V11 said, "I could see the tops of her feet out the front of the quilt. I couldn't see the foot pedals that well."

On 2/27/24 at 9:45 AM, V13 (Registered Nurse) stated she responded to V11's call for assistance. V13 stated when she placed R1's foot on the wheelchair pedal she noticed R1 was experiencing "some discomfort." V13 stated, R1 had a history of a knee replacement and R1 was concerned about that knee because she "tweaked" it during the transfer. V13 stated she worked on 2/13/24 from 2:00 PM till 6:00 PM and she requested an X-ray before leaving her shift.

R1's Progress Notes showed a communication was sent to V15 (R1's Physician) on 2/13/24 at 9:53 PM stating, "Resident had incident today after dinner where she had bumped her left knee [was later corrected to right knee] causing severe discomfort and affected mobility. She stated she had a knee replacement in this knee and reported pain at 10/10 (10 out of 10). She continues to report pain and thinks her knee was twisted during incident with her wheelchair. She is requesting x-ray to left knee to rule out fracture."

R1's X-ray results for her right knee, sent to the facility on 2/14/24 at 2:54 PM, showed an acute

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S9999	Continued From page 6 (sudden or recent onset) nondisplaced (the bone remained in alignment) periprosthetic (fracture around the knee replacement hardware) distal femoral fracture (fracture of the thigh bone at the area just above the knee). The X-ray report showed a handwritten note which stated V15 (R1's Physician) ordered a "knee immobilizer on at all times until she's seen by ortho (orthopedics)." The order showed it was taken at 3:15 PM on 2/14/24. The X-ray report showed V4 (R1's Daughter-in-Law and the spouse to R1's Power of Attorney/V3) was going to get the immobilizer. On 2/22/24 at 1:02 PM, V8 (Licensed Practical Nurse) stated she was one of the nurses who responded to R1 on 2/13/24. V8 stated prior to this incident R1 did not complain of pain to her right leg. V8 stated R1 was admitted to the facility with a cervical fracture and her pain was pertaining to that fracture. V8 stated when she responded to the incident, R1 was complaining of soreness to her right leg and when R1's leg was placed back on the foot pedal she said "ow." V8 said the soles of a resident's feet should be firmly planted on the foot pedals of the wheelchair. V8 said if a resident's feet are not firmly planted there is a risk the persons foot could fall off and go behind them. On 2/23/24 at 9:32 AM, V20 (Certified Nursing Assistant/CNA) stated prior to this incident R1's transfer status was an extensive assist of 2 with a gait belt. (A belt wrapped around the person used by staff to steady and support the resident.) V20 said after the incident R1 required a mechanical crane-type lift for transfers. V20 said, after the incident on 2/13/24, R1 was crying out in pain during mechanical lift transfers. V20 said this pain was new for R1. V20 said she did not	S9999		

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S9999	Continued From page 7 believe, given R1's transfer status prior to 2/13/24, R1 would have had the strength to support her legs during a wheelchair transfer. On 2/27/24 at 10:58 AM, V2 (Director of Nursing) stated regarding transporting residents in wheelchairs, "Prior to this [incident] people were not trained on how to transport residents in a wheelchair, but we are fixing that.... I was aware that there is a possibility of injury with wheelchair transportation. The type of injuries is bumping into them, dropping leg, grabbing the wheels and getting their arms wrapped up in the wheelchair." V2 said interventions to prevent injury from a foot dropping would be, "making sure pedals are in place and make sure feet are on the pedals. The feet are firmly planted in place on the pedal prior to moving the resident. I was told a member from dietary was pushing her out of the dining room and she had some pain in her leg and the dietary aide stopped and called for staff." V2 reviewed a still image of the incident on 2/13/24 at 6:17 PM. V2 stated, "...it does look like the ankle is resting on the side of the pedal. If I was the one transporting her or I saw someone transporting her like that in that position, I would have stopped her and put her feet on the pedal." On 2/22/24 at 4:01 PM, V1 stated the facility does not have a policy discussing the transportation of residents in wheelchairs except for "Assist in the evacuation of residents." The facility's schedule for 2/14/24 showed V10 (Certified Nursing Assistant/CNA) was assigned to R1's hall from 6:00 AM to 2:00 PM. On 2/22/24 at 3:35 PM, V10 stated, regarding her shift on 2/14/24, R1 was experiencing	S9999		

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"excruciating pain." V10 said, "She (R1) likes to sleep on her side, but we tried to repo (reposition) her, and she cried out in pain when we moved her...We did tell the on-coming CNAs that she was having a lot of pain with any movement." V10 said she did not transfer R1 out of bed her entire shift due to R1's pain with movement.

On 2/22/24 at 3:44 PM, V9 (CNA) stated she worked 6:00 AM to 6:00 PM on 2/14/24. V9 stated, regarding R1's transfer the evening of 2/14/24, "We talked her into getting up for dinner. She hollered out in pain, but we talked her through it. I think it was her right leg. She was hesitant to get up. The nurses did not say don't transfer her. I heard there was a fracture of the knee, so we tried to support it during the transfer...She didn't refuse the transfer even when she was screaming; she didn't say to stop..."

On 2/23/24 at 9:32 AM, V20 (CNA) stated she assisted with R1's transfer the evening of 2/14/24. V20 said, "I did transfer her (R1) out of bed the next day for dinner because she wanted to go eat dinner. During the transfer, she did cry out in a lot of pain. We asked the nurse if it was okay to transfer and she said it was okay and she said to be very careful, which is why we used the (mechanical crane-type lift). That was my first time transferring someone with a fresh fracture. She was yelling out in pain, we offered to lay her back down, but she just wanted to go eat. Even rolling her she was in a lot of pain. If I was told by the nurse not to transfer her, I would not have transferred her. I was not there when the family came in with the immobilizer to transfer her back to bed."

(The following interviews with R1's family were

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S9999	Continued From page 9 conducted as a group interview on 2/22/24 at 10:12 AM. In attendance were, V3 (R1's Power of Attorney/Son); V4 (R1's Daughter-in-Law and spouse to V3); V5 (R1's Daughter); V6 (R1's Son); V16 (R1's Daughter-in-Law and spouse to V6); V17 (R1's Son); and V7 (R1's Daughter.) On 2/22/24 at 10:12 AM, V4 (R1's Daughter-in-Law) stated she was a Registered Nurse. V4 stated she came to the facility on 2/14/24 to measure R1 for the knee immobilizer. V4 stated R1 was in bed at that time. V4 stated she returned that evening, around 6:00 PM, with the immobilizer and R1 was in the wheelchair. V4 said, "I can't believe they moved her from the bed to the wheelchair with a fracture and without the immobilizer. They knew she had a new fracture at that point and the moved her anyway." V4 stated she was unable to apply the immobilizer with R1 in the wheelchair "so we (mechanical crane-type lift) her back to bed." V4 stated the transfer back to bed "...was the most horrible thing I have ever seen; I really don't want to talk about." V4 stated, R1 was crying and screaming with pain during the transfer back to bed. On 2/22/24 at 10:12 AM, V5 stated she is a Physical Therapy Assistant. V5 stated she was contacted by V4 regarding R1's transfer the evening of 2/14/24. V5 said, "They never should have transferred her. When [V4] told me that I called and spoke to the nurse...I think it was [V13 Registered Nurse] and I told her do not transfer her [R1]. I told her put a note in the chart or do whatever you have to, but do not transfer her and we would be in the next morning to have her sent to the ER for evaluation. [V4] came in the next morning and they had transferred her into a wheelchair."	S9999		

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S9999	Continued From page 10 On 2/22/24 at 10:12 AM, V4 stated, "I came in the next morning, and they had transferred her to a wheelchair. I had had enough and said let's send her out. I could not be in the room to watch them transfer her from the wheelchair to the bed. It was such a horrible event from the day before. I couldn't watch her go through that again, but I could hear her scream in pain through the door. If they had left her in bed, she would have had much less pain when she was transferred to the cot for EMS transport." On 2/27/24 at 9:45 AM, V13 (RN) stated she had numerous conversations with R1's family. V13 denied being told she should not transfer R1. On 2/23/24 at 12:11 PM, V18 (CNA) stated she worked on 2/13/24 and 2/14/24 from 6:00 PM to 10:00 PM. V18 stated she did not transfer R1; however, she assisted the family with applying R1's immobilizer (evening of 2/14/24). V18 said, R1 was having "quite a bit of pain." V18 said, "Her Daughter-in-Law said let's keep her in bed the next couple of days..." V18 stated "We passed it on in report that she should stay in bed, and I think one of the nurses was in the room when the daughter told us that, but I don't remember which one was in the room. The daughter wanted to keep her in bed the next couple of days because (R1) was yelling out with pain with the slightest bit of movement. She would say ow if you rolled her but, the amount of pain she was having was more than she normally had. I was not used to her screaming out in pain; it broke my heart." On 2/22/24 at 2:30 PM, V12 (Assistant Director of Nursing) stated she was R1's nurse on 2/14/24 from 6:00 AM to 6:00 PM. V12 stated the CNAs did transfer R1 to the wheelchair for dinner the	S9999		

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evening of 2/14/24. V12 stated it was not discussed if R1 should not be transferred and she did not tell the CNAs to keep R1 in bed. V12 said the purpose of the immobilizer is to "...keep it (her leg/knee) from moving and hurting her..."

On 2/23/24 at 9:15 AM, V21 (CNA) stated she transferred R1 the morning of 2/15/24 from the bed to the wheelchair then back again. V21 said, "...Yes, she was yelling out in pain. She kept saying, 'my leg, my leg.' But once we got her in the chair, she was comfortable...Her daughter showed up. The daughter said she had to step out for the transfer to bed because she couldn't stand to see her like that...She was yelling out in pain for the transfer to the bed. And then after the transfer she was grimacing in pain, so we tried to prop up her leg. I was never told not to transfer, I actually asked if we should transfer her. Sometimes the family will request not to get her up. I asked [V14 Registered Nurse] if we should get her up..."

On 2/27/24 at 9:44 AM, V14 stated she was not in the room for R1's transfer to the wheelchair or back to bed. V14 said, R1 was transferred out of bed sometime on 2/15/24 between 7:30 AM and 8:00 AM. V14 said, the CNAs brought R1, in the wheelchair, to her and she gave R1 her pain medication after the transfer. V14 said, R1 was having pain at the time she gave her the oxycodone (narcotic pain medication.) V14 said, "In light of everything, in hindsight, she should have been given the oxycodone before the transfer. We do try to premedicate before an uncomfortable event."

R1's February 2024 Medication Administration Record (MAR) showed, prior to the incident on 2/13/24, R1 took as needed pain medication

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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 12	S9999		

(oxycodone, narcotic pain medication) twice, once on 2/9/24 and again on 2/11/24. The MAR showed after the incident on 2/13/24 R1 was given 6 doses of as needed pain medication from 2/13/24 through 2/15/24. R1's February 2024 Medication Administration Record (MAR) showed V14 documented R1 was given oxycodone at 8:01 AM for pain at a 10 out of 10. The MAR showed the dose before this was given at 7:15 PM on 2/14/24. (Nearly 13 hours prior)

The National Library of Medicine online article titled oxycodone (updated 8/22/22) showed the effective duration of oxycodone to be 3-6 hours.

R1's Physician Communication from 2/14/24 at 10:27 PM, showed "Resident is in extreme pain rating 10/10 (10 out of 10). Within 1.5 hours of med administration, she is requesting more medication. Can this dose be increased? Any movement or repositioning seems to obviously aggravate her leg. She also has immobilizer on at this time. Please advise."

The facility's Pain Management policy (revised 3/2017) showed, "It is the policy of this facility to provide skilled assessment and appropriate treatment of the resident experiencing pain...the licensed nurse will administer medications and treatments as prescribed by the physician providing safe and effective pain relief..."

The facility's Dietary Aide Job Description (not dated) did show resident transportation in the job description.

The facility's Certified Nursing Assistant Job Description (not dated) showed "...Assist in transporting residents to/from appointments,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000962	A. BUILDING: _____ B. WING _____	C 02/29/2024

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S9999	Continued From page 13 activity and social programs, etc. as necessary. Assist with lifting, turning, moving, positioning, and transporting residents into and out of beds, chairs, wheelchairs, lifts, etc..." "A"	S9999		