Final Observations

Statement of Licensure Violation:

300.1210b)
300.1210d)(5)(6)
300.3240a)

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:

5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

6) All necessary precautions shall be taken...
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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.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)

These Requirements are not met as evidenced by:

Based on interview and record review, the facility failed to use two or more staff to safely transfer a resident (R2) and failed to complete a wheelchair assessment (R3) for two of three residents reviewed for falls, in the sample of 21. These failures resulted in R2 sustaining a femur fracture and R3 sustaining an orbital fracture.

Findings include:

1. Review of the facility’s final incident report of 07/13/2017, notes in part: On 10 July 2017, R2’s knee buckled during an assisted transfer from her bed to her wheelchair, she was eased to the floor, landing on her left knee. (Z6) was notified, with orders to obtain an x-ray. Radiology report was positive for fracture, and orders were received to
Continued From page 2

send resident to the hospital for further evaluation. (R2) was admitted with a diagnosis of fractured femur.

Review of R2's medical record (Face Sheet) notes, R2 was admitted to the facility with diagnoses including but not limited to: Acute Respiratory Failure, Hypertension, Pneumonia, Congestive Heart Failure, History of Fall.

Review of R2's care plans notes the following: Problems
-Resident is at risk for falls related to poor safety awareness, need for staff to assist with ADLs (Activities of Daily Living) including mobility
-Interventions
Assist of two staff with all repositioning needs (07/27/2016)

MDS (Minimum Data Set) 06/19/2017
-Functional Status
Transfer: 3/3 (Extensive assistance/Two+ persons physical assist).

9/13/2017 at 3:53 PM E8 (CNA) stated, she got R2 up from the bed by herself (using a gait belt) to a standing position. R2 complained that her legs hurt and started going down. E8 eased R2 to the floor.

2. Review of R3’s medical record (Face Sheet) states, R3 was admitted to the facility with diagnoses including but not limited to: Acute and Chronic Respiratory Failure, Pneumonia, Chronic Obstructive Pulmonary Disease and History of falls.

Review of the facility's incident (08/30/2017) report,
Continued From page 3

Brief Description of Incident: (R3) fell from a personal wheelchair brought to the facility by family member. Immediate Action Taken: There was a small laceration above the left eye, pressure was applied to the area. Physician was called, gave orders to transfer to the nearest hospital for further assessment via 911. Resident was transferred to local hospital and admitted to trauma unit for further observation. Facts Determined: Family member wanted resident transferred to a travel wheelchair he brought from home. Family member insisted that the resident’s wheelchair cushion be used with the travel wheelchair. The nurse educated family member that the cushion was not appropriate for the travel chair, the family member insisted it be used and despite repeated objections by the nurse that the resident’s center of gravity would be changed and she could fall. The family member stated “we use this chair all the time with this cushion and there isn’t a problem, just get her ready so we can leave. While sitting in the chair, the resident pushed up on the wheelchair arms with her hands and tried to reposition herself, she fell forward and hit her head. (R3) fell because of bilateral lower extremity weakness and having her regular wheelchair cushion used in a travel wheelchair. She lost her center of gravity when she attempted to reposition herself by pushing up on the siderail armrests of the travel wheelchair brought from home by family member and his insistence in using the elevated seat cushion of three inches in the travel wheelchair. Resident returned to the facility on 08/28/2017 with a diagnosis of Left Orbital Floor Fracture and a 1.5 inch laceration at the left brow line that was closed using surgical glue.

On 9/19/17 at 9:52 AM E14 (Licensed Practical
S9999  Continued From page 4

Nurse), said "R2's family member tries to do things he's not supposed to do". She said she told family member that the travel wheelchair was inappropriate for R3 because the arm rests were too short and cushion raised R2 up too high in the travel wheelchair. No wheelchair assessment for travel wheelchair was found.

(B)