STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003057	A. BUILDING _____ B. WING _____	C 04/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE OF LAGRANGE PARK, THE	701 NORTH LAGRANGE ROAD LA GRANGE PARK, IL 60526

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S 000	Initial Comments Complaint Investigation: #1972687/IL111282	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.1210b) 300.1210c) 300.1210d)6) 300.1220b)3) 300.3240a) 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. Restorative measures shall include, at a minimum, the following procedures: c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: 6) All necessary precautions shall be taken to assure that the residents' environment	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

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 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These requirements were not met as evidenced by:

Based on interview and record review, the facility failed to ensure that a resident with a known skin condition was transferred safely. As a result of an improper transfer, R1 sustained a laceration that required 62 sutures to close.

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S9999	Continued From page 2	S9999		

This applies to 1 of 3 residents (R1) reviewed for safe transfers in the sample of 3.

The findings include:

R1's face sheet showed R1 has multiple diagnoses which included dermatomyositis and diabetes.

R1's quarterly MDS (minimum data set) dated 2/16/19 shows a BIMS (Brief Interview for Mental Status) score of "15" which means that the resident is cognitively intact. The same MDS showed R1 required extensive assistance from the staff with regards for transfer with the assist of 2 persons.

On 4/12/19 at 4:31 PM, hospital records showed R1 was received at the Emergency Room for a laceration of the lower left leg that required 62 sutures to close.

On 4/12/19 at 4:02 PM, V8's (Nurse Practitioner) progress note showed R1 was observed to "have a long skin tear to LLE (lower left extremity) with acute bleeding and exposed adipose tissue, complete tissue loss." Same progress note showed V8 was "asked by staff to see the resident due to skin tear to LLE while transferring patient from recliner to her bed."

Incident report completed on 4/9/19 showed R1 sustained a skin tear on the right lower leg. The progress note dated 4/9/19 at 9:04 PM showed "while the CNA (certified nursing assistant) transfer the resident to the wheelchair, the resident was scooting back in the chair and scraped right calf on the wheelchair ...steristrips were applied and covered with derma rite.

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S9999	Continued From page 3	S9999		

R1's transfer assessments on 12/19/18 and quarterly assessment on 2/10/19 completed by V7 (restorative nurse) both showed "based on the amount of "yes" answers to the questions in section 'Transfer Ability', R1 required assistance of two or more persons and required mechanical sit to stand lift. Those same reports showed R1 had not been observed for steadiness when moving from seated to standing position.

R1's current transfer care plan shows that the resident required 2 staff physical assistance with transferring and to allow R1 to "position her leg with one foot forward to promote balance as she comes to stand." R1's care plan did not indicate the use of mechanical lift for transfer.

On 4/16/19 at 12:10 PM, V4 (CNA) stated she was assigned to R1 on 4/12/19 and asked V5 (CNA) for assistance to transfer R1 from the reclining chair to the bed. V4 stated she was positioned on the side of the recliner chair and V5 was in front of R1. V4 added that as R1 stood, V5 grabbed R1 under the arms, pivoted R1 and alone, transferred R1 to the bed. V4 stated she did not have her hands on R1 during the transfer. V4 stated gait belt was not used. V4 added that she had transferred R1 earlier in the shift using a mechanical lift, because it was easier and safer.

On 4/16/19 at 1:20 PM, V5 stated he assisted putting R1 back to bed by lifting underneath R1's arms, pivoting R1 and sat R1 on the bed. V5 added the moment R1 sat down, R1 said "my leg, my leg." V5 stated they looked down to check R1's right leg because they were aware of the right leg injury, Then, R1's left leg noted dripping blood from underneath R1's black pant leg.

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S9999	Continued From page 4 On 4/17/19 at 3:00 PM in the presence of V1 (administrator), V7 (Restrorative Nurse) stated R1 should not have been transferred from a recliner chair and there should be more communication with staff during transfers to ensure everyone, including the resident, will know what will take place and what assistance is needed. On 4/17/19 at 1:35 PM, V9 (physician) stated R1 has a skin condition that puts her at risk for injury. V9 stated the facility is aware and has measures in place: putting R1 on a special mattress, elevating R1's legs when in bed, bathing R1 with soft towels to prevent skin injuries and wrapping R1's legs with gauze as a preventative measures. V9 acknowledged he was aware that R1 has sustained a skin tear to the opposite leg during transfer on the 4/9/19 and no new interventions were put into place to prevent future occurrences. V9 added that, in hindsight, R1's care should have been updated o include; placed in a padded chair, with padding on the leg extenders and gauze around legs to protect R1. (A)	S9999		