STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013312	A. BUILDING: _____ B. WING _____	C 06/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEYVILLE MANOR	1251 NORTH STATE STREET JERSEYVILLE, IL 62052

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S 000	Initial Comments Complaint #1944189/IL112917	S 000		
S9999	Final Observations Statement of Licensure Violation: 1 of 1 Violation 300.610a) 300.1210b)5) 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 300.1210 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: 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: 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. 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 regulations were not met as evidence by: Based on observation, record review and interview, the facility failed to provide safe transfers for 2 of 5 residents (R1, R3) reviewed for transfers in the sample of 5. This failure resulted in R3's fall and right femur fracture. Findings include: 1. R3's Resident Face Sheet, dated 6/13/19,	S9999		

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S9999	Continued From page 2	S9999		

documents diagnoses of Unspecified dementia with behavioral disturbance, Contracture right hand, Contracture, left hand, Other osteoporosis without current pathological fracture, Unspecified fracture of lower end of right femur, Contracture right knee, Contracture left knee, and Unspecified convulsions.

R3's Minimum Data Set, dated 4/23/19, documents a Brief Interview for Mental Status (BIMS) score of 0, severely impaired cognition and totally dependent on 2 person physical assist for bed mobility and transfers.

R3's Care Plan, dated 11/19/13, documents, "Bed in lowest position." It continues, "Approach start date: 9/27/17 Full mechanical lift for all transfers."

R3's Fall Risk Assessment Tool, dated 10/20/18, documents, "Total fall Risk Score: Score: 19 Level: High Fall Risk."

On 6/11/19 at 8:35 am,V17, R3's wife, stated, "I was told they were putting (R3) in (R3's) chair using the lift and they dropped (R3)."

R3's Progress Note, dated 6/2/19 at 11:47 am, V13, License Practical Nurse (LPN), documented "Writer called to room, resident observed lying somewhat on back side, weight on left shoulder and left hip. Eyes open. ROM (Range of Motion) x (times) 4 without pain/limitations per norm." It continues, "Small red area noted to L (left) eyebrow at this time measuring 1 cm (centimeter) in length. CNA (Certified Nurses Assistant) reports, "I got (R3) ready and on (R3's) (mechanical lift) pad, I turned around to grab (high back reclining geriatric) chair and resident fell to floor."

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R3's Progress Note, dated 6/8/19 at 8:55 PM, V14, Registered Nurse (RN), documented, "Received report on resident regarding yellow bruising on right side. Writer observed yellow bruising from top of right hip to mid calf with noted dark purple behind right knee. Hospice nurse, (V11), here visiting another patient and agreed to look at resident. She notified the MD (Medical Doctor) and received orders to have right hip, femur and knee x-rays done. (X-ray company) called and made aware of stat order."

R3's Patient Report of the Right Radiologic Examination, Femur; Minimum of 2 Views, dated 6/8/19, documents, "Impression: 1. Acute distal femoral metaphyseal fracture. 2. Fixated intertrochanteric hip fracture with intact hardware."

R3's Evaluation Notes, V2, Director of Nurses (DON), dated 6/10/19, documents, "It is felt that the resident sustained fracture at the time of fall on 6/2/19, due to resident having no other occurrences from time of fall to current date."

R3's Progress Note, dated 6/10/19 at 6:39 am, "Resident moaning, prn (as needed) Morphine given. Hospice nurse/ NP (V12, Nurse Practitioner) notified of resident condition and received orders to ace wrap or immobilize right femur. Immobilizer put in place."

On 6/12/19 at 1:25 PM, V21, CNA, stated, "(R3) was close to the edge of the bed, I was by myself, I went out to the hallway to get (R3's) (high back reclining geriatric chair) and when I came back in and (R3) was on the floor. (R3) was shaking a lot."

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S9999	Continued From page 4 On 6/13/19 at 10:21 am, V13, LPN, stated, "I was called into the residents (R3's) room by CNA, and (R3) was lying on the floor, on (R3's) back with most of (R3's) weight shifted to the right side toward the door to the hallway. We got (R3) back in bed, I pulled up (R3's) shirt to look at (R3's) back and then pulled down (R3's) pants, but not all the way down, to check (R3's) bottom and legs. I didn't see any injuries to those areas" V13, stated, " the (high back reclining geriatric chair) was in the hallway because the rooms are too small." V13, further stated, "When I worked last weekend, I reported to the next nurse, (V14), about, (R3's), yellow bruising to (R3's) right leg." On 6/12/19 at 12:44 PM, V11, Hospice RN, stated, "I was in the building that day (6/8/19), admitting another resident, and was told about (R3's) leg pain. I saw the yellow bruising, notified the doctor (V15) and he ordered an x-ray of the right hip, femur and knee to be done." V11 also stated yellow bruising would be an old bruise. On 6/13/19 at 2:20 PM,V12, Nurse Practitioner, stated, "I'm not sure if the fall caused this fracture because (R3) has severe osteoarthritis but it could have possibly caused a hairline fracture." V12 continued, "Given the information, for example (R3) was left to close to the edge of the bed and no supervision when the CNA left the room to retrieve (R3's) wheelchair, then yes, the fall could have been avoided." On 6/13/19 at 2:05 PM, R3 had a faint yellowish bruise noted from R3's lateral right hip down to just above R3's lateral right knee and on the back of R3's right knee was a faint brownish bruise. R3's right side of bed faces the door to the hallway.	S9999		

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On 6/12/19 at 10:15 am, V21 and V4, CNA's, used the full mechanical lift to transfer R3 from the bed to the high back, reclining geriatric chair. Neither CNA checked that all the lift pad straps were secure before further lifting R3 off of the bed. V21 did not maintain contact with R3's bilateral legs during transfer, allowing R3's legs to dangle. Neither V3 or V4 locked the high back, reclining geriatric chair wheels during lowering to the chair.

On 6/12/19 at 1:49 PM, V2, DON, stated," I would expect the staff to check a residents skin after a fall, even if staff has to remove the pants and shirt." It continues, " I also expect them to do range of motion."

2. On 6/12/19 at 11:30 am, V18, V19 and V20, CNA's, used the full mechanical lift to transfer R1 from the bed to the wheelchair. None of the CNA's checked the lift pad straps were secure before further lifting R1 off of the bed. V20, CNA, did not maintain contact with R1's legs during transport, allowing R1 to dangle and spin in a circle while up in the air. Neither V18, V19 or V20 locked the brakes on R1's wheelchair prior to lowering him into it.

R1's MDS, dated 4/23/19, documents BIMS score of 08, moderately impaired cognition and totally dependent for transfers with 2 person physical assist.

R1's Care Plan, dated 10/31/19, documents, "Approach Start Date: 10/31/18. Safe resident handling procedures: Transfer method: Full body mechanical lift, x-large long seat sling. Level of assistance: Assist x (times) 2."

R1's Fall Risk Assessment Tool, dated 3/7/19,

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S9999	Continued From page 6 documents, "Total Fall Risk Score: Score: 21 Level: High Fall Risk." On 6/13/19 at 3:00 PM, V2, DON, stated, "We don't have a policy or procedure for the (full mechanical lifts) but we have the staff watch a video about it." V2 further stated, "We don't have a transcript of the video." V2 further stated, "I don't expect the staff to lock the brakes of the wheelchair because they were taught not to lock the brakes of the wheelchair or bed." Facility policy, "Safe Resident Handling", dated 11/12, documents, "All staff members required to use the lifting devices will be oriented and trained on the proper use." User Manual for the full mechanical lift, not dated, documents, "If the resident is being lifted from a wheelchair or transfer chair or bed, ensure brakes on the chair or bed are locked." It continues, "Lift resident 1-2 inches over bed or chair, stop and then check that all straps are secure, the sling is holding resident before further lifting." (B)	S9999		