Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013072	A. BUILDING: ______ B. WING ______	C 05/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED METHODIST VILLAGE, NORTH CAMPI	2101 JAMES STREET LAWRENCEVILLE, IL 62439

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S 000	Initial Comments Complaints: 1752752 / IL 93864 - F323 1752753 / IL 93865 - F323	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210d)6) 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: 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:	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE 05/19/17

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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. (Section 2-107 of the Act)

These Regulations were not met as evidenced by:

Based on interview and record review the facility failed to secure a mechanical lift sling to the mechanical lift hooks and implement fall prevention interventions for one resident (R3) reviewed for falls. This failure resulted in R3 falling out of a mechanical lift, sustaining bilateral femur fractures, and undergoing an open reduction internal fixation surgical procedure for those fractures.

The findings include:

According to the Quarterly Minimum Data Sets (MDS) dated March 20, 2017 R3 is 86 years old This same MDS scores R3's Brief Interview for Mental Status (BIMS) as 15 indicating R3 is cognitively intact, scored E300 as a zero indicating R3 has no behaviors and scored the following on R3's functional status: Totally dependent with 2 persons physically assisting with bed mobility, transfers, dressing, toilet use, and bathing. This same MDS lists R3 as not

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steady, only able to stabilize with staff assistance with moving on and off toilet, surface to surface transfers, and moving from seated to standing position, walking, or turning around and facing the opposite direction while walking was coded as an 8 indicating that activity did not occur.

R3's physician's order sheet dated May, 2017 lists on 12/14/2016 "Hoyer (formal name of a mechanical lift) lift to transfer."

R3's care plan with a start date of 12/14/2016 under the category of falls lists "(formal name of R3) is at risk for injuries from falls r/t (related to) limited mobility, impaired balance, weakness, ...he does not ambulate and transfer with hoyer lift." This same care plan lists a mechanical lift is to be used for transfers in three more of the interventions under falls.

Interdisciplinary notes dated May 2, 2017 at 17:45 (5:45 PM) states R3 was noted on the floor and was transferred from the floor to the bed with a mechanical lift.

The Central Office Notification report for R3 dated May 3, 2017 at 3:45 PM and states "he fell in his room while transferring...Sent to (formal name of local hospital) for eval. (evaluation) X-ray reveals bilateral distal femoral fractures. Being sent on to (out of state hospital) for orthopedic consult."

The local hospital "Chief Complaint/History of Present Illness" report for R3 with an exam date of 5/2/2017 at 17:54 (5:54 PM) states : "86 YR (year old) male from NH (nursing home) with pain both knees, R (right) hip, and also hit head. Was being transferred at the NH in hoyer lift and pt (patient) fell with resultant injuries." On the same document under Past Medical and Surgical

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History: "positive (has had in the past) for bilateral knee replacements," under "Physical Examination" at 21:14 (9:14 PM) "Patient in moderate distress," and under "Consultation and Critical Thinking" at 21:08 (9:08 PM) "Discussed with (formal name of orthopedic physician at an out of state hospital) will do the ortho surgery but patient needs trauma service or internal medicine to manage patient's other medical problems. To be transferred to (formal name of out of state hospital) ER (emergency room)...Prognosis is guarded." On this same document under "Clinical Impression" the following is listed "1. Fall, 2. Bilateral Distal Femur Fractures, 3. Closed Head injury, 4. Contusion R (right) hip" and under "Disposition: Condition: Critical."

R3's Radiology Reports from the local hospital emergency room dated May 2, 2017 states for the Pelvic and right hip radiographs "Osteopenia without definite evidence of acute fracture or dislocation." The CAT (computerized axial tomography) scan without contrast lists "Impression : No acute intracranial abnormality." The Three-view right knee lists findings as "Comminuted distal femoral fracture is seen. just above the prosthesis, with posterior displacement and Mild anterior angulation. Large joint effusions is present. Prosthesis remains intact, with the Impression as Distal femoral fracture" and the Three-view left knee lists findings as "Comminuted spiral fracture involves the distal femur, with mild posterior displacement anterior angulation. Large joint effusion is present. The prosthesis is intact. The anterior fracture extends to the anterior proximal prosthesis. Impression Communited distal femoral fracture."

The out of state hospital history and physical consultation note dated May 3, 2017 under

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subjective states "(formal name of R3) presents with bilateral knee pain. He complains of severe pain located just above both knees since yesterday. He admits to immediate pain at both knees... Mechanism of injury was fall from Hoyer lift because strap broke at nursing home." Another note on this same document dated May 4, 2017 under "Assessment: Post-Operative Day: 1. Status Post: ORIF (according to 'orthopaedics.com.sg' defines ORIF as an open reduction internal fixation, which is a surgical procedure to fix a severe bone fracture or break. "Open reduction" means surgery is needed to realign the bone fracture into the normal position. "Internal fixation" refers to the steel rods, screws, or plates used to keep the bone fracture stable in order to heal the right way and to help prevent infection.") B (both) periprosthetic distal femur fractures."

The facilities Resident's Incident Report for R3 dated May 2, 2017 answers the question of "3. Were environmental factors an issue? yes, equipment use - One strap of hoyer sling not properly fastened." On this same document number 4 question of What was the resident doing was answered as "2 staff were transferring (R3) from the bed to wheel chair at time of fall", and under number 8 Pain Assessment states "Complained of pain to bilateral knees" and finally, under the Risk Manager's Investigation: "(R3) fell to the floor from the hoyer sling. R3 was being transferred from the bed to the wheelchair at the time of fall. Two staff were assisting with transfer/hoyer lift. One of the straps was not properly fastened - secured to the hook on the hoyer lift. Resident immediately complained of pain to bilateral knees....New orders received to send resident to (formal name of local hospital) emergency room for evaluation. X-rays indicated

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fractures to bilateral lower extremities, resident was transferred to (formal name of out of state hospital) for surgical repair. A new hoyer lift was purchased as well as new U shaped padded slings for each resident. Currently in the process of in servicing all nursing staff on safe transfers with the hoyer lift and use of the new slings."

Personnel Action Forms dated May 3, 2017 with an incident date of May 2, 2017 for E3 and E9 (both Certified Nurse Aides) indicates E3 and E9 received written disciplinary action for "Improper use of hoyer - did not get pad correctly attached - Resident fell out of lift pad and had serious injury.

An undated written statement signed by E9 states "I thought the loop on the hoyer pad had broke, but it hadn't." The mechanical lift sling used to transfer R3 was examined on May 5, 2017 by this surveyor and the loops on the straps were in tact and no fraying or damage was noted.

An undated written statement signed by E3 states "I and another CNA (Certified Nurses Aide) were getting (R3) up in a wheelchair for supper and had him hooked to hoyer pad and the left side popped undone and he fell to floor on his left side."

An interview on May 9, 2017 with R6, who presented as alert and oriented to person, place and time, stated that "I was present in the room when R3 fell. They got him up, I saw the strap was loose from the machine, he flipped over and fell on his left side and hit his head on the floor. They get him up with the lift 2 to 3 times a day. Sometimes the lift does not work properly but this has not happened before. Once he was in the bathroom and his nose started bleeding after he was taken to the bathroom and I think they used

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a lift, but not sure. This girl has transferred him about 3 or 4 times."

An interview on May 5, 2017 at 4:45 PM, E3, Certified Nurses Aide (CNA) states "I was on the resident's left side, I hooked up the left side of the sling on the mechanical lift hooks. (E9) lifted R3 and he was in the air for a few minutes and while I was trying to adjust his wheelchair and the loop that was suppose to be on the hook popped. When I heard the pop I pushed the wheel chair out of the way so he wouldn't hit it and tried to catch him so he wouldn't hit the floor. I didn't hook the loop on the hook properly. He hit on his left side and knee, then shoulder. His shoulder kind of protected his head."

An interview on May 5, 2017 at 3:30 PM, E2, Director of Nursing states "As a result of our investigation, we determined the mechanical lift sling loop wasn't hooked on the lift hook properly which caused the left side of the sling to give way and he (R3) fell. We disciplined both CNA's, and took the lift out of use and started using another lift we had in the building at the time we were considering purchasing."

(A)