STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006506	A. BUILDING: _____ B. WING _____	09/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESENCE NAZARETHVILLE	300 NORTH RIVER ROAD DES PLAINES, IL 60016

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S 000	Initial Comments Annual Licensure and Certification	S 000		
S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS: 300.610a) 300.610c)4)F) 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. c) The written policies shall include, at a minimum the following provisions: 4) A policy to identify, assess, and develop	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a resident. The policy shall establish a process that, at a minimum, includes all of the following: F) Development of strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a resident; and 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: 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,	S9999		

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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. (Section 2-107 of the Act)

These regulations are not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure that staff safely utilized a mechanical lift which affected one resident (R3) of ten residents reviewed for falls and accidents/supervision in a sample of 15. These failures resulted in R3 sustaining an intracranial hemorrhage after slipping out of a mechanical lift sling and hitting her head on the floor. This injury required a seven day hospital stay.

Findings include:

R3's Face Sheet documents, in part, the following medical diagnoses: Admit Diagnosis: Multiple Sclerosis and Paraplegia.

On 9/25/17 at 10:35am, R3 was asked if she had

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any issues with staff. R3 shook her head and stated, "Except when they dropped me on my head. It happened two months ago. They didn't think I would make it. I was on Hospice and the whole nine yards. Hospice made me feel helpless. Like they were just waiting for me to die."

R3's Minimum Data Set (MDS) dated 5/9/17 documents: Transfer. R3 is coded as a 4 (Total dependence) for Self Performance and a 3 (Two + persons physical assist) for Support.
R3's MDS dated 8/3/17 documents a BIMS (Brief Interview of Mental Status) score of 15 out of 15 which indicates that R3 is Cognitively Intact.

R3's Care Plan indicates, in part: Problem: Multiple Sclerosis, needs mechanical lift for transfers due to contractures, paraplegia LE (lower extremities). Is non-ambulatory and needs extensive assist with bed mobility. 7/11/17 - Fell while being transferred with (mechanical) lift, hit head. Sent to hospital.

A facility generated Resident Incident Report denotes that on 7/11/17 at 9:30am, R3 experienced a fall while being transferred via manual lift by E5 (CNA-Certified Nurse Assistant) and E6 (CNA). The report documents the following: Narrative of incident and description of injuries: (R3) was being transferred via (mechanical) lift from bed to wheelchair, slipped out of sling on to floor hitting her head. Abrasion on left occipital area of head approximately 2 (two) centimeters in diameter. Immediate actions taken: Pressure applied to head to stop bleeding and ice pack applied, assisted to bed with four (4) assists.
This report indicates that R3 was transferred to a local hospital emergency room on 7/11/17 at

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11:16am. The transfer is also documented in R3's Departmental Notes.
On 7/11/17 at 10:27pm, the following is documented in R3's Departmental Notes: Verified at (local hospital emergency room) resident admitted with a diagnosis of ICH (Intracranial Hemorrhage).
R3's head injury required a seven day hospital stay. R3's Departmental Note dated 7/18/17 at 9:01pm documents that R3 was re-admitted to the facility from the local hospital.

On 9/26/17 at 10:04am, E6 (CNA) indicated that on 7/11/17 she requested assistance from E5 (CNA) for the mechanical lift transfer of R3 from the bed to the wheelchair. E6 stated, "I stood on (R3's) left side. (E5) did not hook the right side (of mechanical lift) sling correctly. We picked (R3) up off the bed using (mechanical lift). When we swung her from the bed, the top right loop came undone. Because of the loop, the right side came loose. (R3) fell to the left and hit head on the floor but her legs were still looped in the sling by the leg part. Head started bleeding. Me and (E5) got blood on both of us." E6 continued, "So, the first thing we should do before we mobilize the resident is check the hooks. I pulled on my side but I didn't pull on (E5's) side. This is how we make sure the loops are secure."

On 9/26/17 at 10:11am, E5 confirmed that she assisted E6 with R3's transfer using a mechanical lift. E5 stated, "One hook on my side came loose. I thought I hooked it correctly. But when (R3) shook it came loose."

E8 (RN-Registered Nurse) confirmed that she was the float nurse on 7/11/17 and responded to R3's incident. On 9/26/17 at 9:52am, E8 confirmed that the E5 and E6 told her that one of

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the straps came off the mechanical lift.

On 9/26/17 at 10:35am, E2 (DON-Director of Nursing) demonstrated how the loops should be secured on the actual mechanical lift that was used for R3's transport on 7/11/17. E2 indicated that the mechanical lift was removed from the unit after the incident. E2 stated, "It can actually be in use because it was no fault of the machine." E2 demonstrated that a spring loaded black rubber washer has to be pushed down, the loops placed on hook while the rubber piece is pressed down and when released, E2 demonstrated that the straps remain secured and cannot move.
E2 stated, "We concluded that the one strap was not secured fully." E2 confirmed that R3's fall incident occurred because of operator error. E2 confirmed that the mechanical lift was functionally sound. E2 stated, "Moving forward, staff should check all straps before moving the resident in (a mechanical lift). Now CNA's are responsible for checking each other's straps."

On 9/26/17 at 11:25am, Z1 (Physician/Medical Director) indicated that R3 suffered a subdural hemorrhage after the incident. Not sure of her prognosis so she was placed on Hospice. Initially on Hospice due to lethargy and decline from Intracranial Hemorrhage. She just wanted to be left alone, no treatment, no surgery." Z1 acknowledged that it was an avoidable accident.

After the incident, R3 was placed on Hospice on 7/17/17 with a primary diagnosis of Traumatic subdural hemorrhage without loss of consciousness and Traumatic subarachnoid hemorrhage without loss of consciousness.

On 9/26/17 at 2:25pm, R3 stated, "The staff dropped me on my head when they used the

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machine. That was horrible and it almost did me in. On Hospice afterwards because I couldn't eat, drink, move. I really declined."

On 9/27/17, both Z3 (OT-Occupational Therapy) and Z4 (PTA-Physical Therapy Assistant) confirmed that R3 declined greatly after the fall and it took one month for R3 to regain her strength to baseline.

R3's Emergency Room Notes dated 7/11/17 document a service time of 2:36pm. R3's admitting diagnosis: Acute subdural hematoma; Fall; Subarachnoid hematoma. Discharge Disposition: Admit to SICU (Surgical Intensive Care Unit).
R3's Computerized Tomography of the brain without contrast which was performed on 7/11/17-IMPRESSION: Right subdural hematoma and small left subarachnoid hemorrhage.
Z5's (Neurosurgeon) Consultant Notes dated 7/11/17 confirm that R3 was admitted to a local hospital with a Right Acute Subdural Hemorrhage.
Z1's (Physician) Notes dated 7/11/17 document that R3 was diagnosed with a subdural hematoma and a small subarachnoid hemorrhage.

On 9/27/17, E2 indicated that the facility does not have a policy that outlines how to use a mechanical lift. E2 indicated that staff are trained annually and upon hire.

A facility policy dated 1/7/13 and titled, "Safe Patient/Resident Handling and Movement" documents, in part: 4. Employee Responsibility for Safety: b. Use mechanical lifts, devices and other approved aids in accordance with instructions and training.

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