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S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS: 300.610a) 300.1210b) 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 resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing	S9999	Attachment A Statement of Licensure Violations	

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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. (Section 2-107 of the Act)

THESE REGULATIONS WERE NOT MET AS EVIDENCED BY:

Based on record review and interview, the facility failed to ensure that R3's wheelchair was safely secured in the facility van during transportation. This failure resulted in R3's wheelchair rolling forward, causing a laceration to R3's right leg requiring 21 sutures. R3 is one of three residents reviewed for accidents in the sample of three. The facility staff also failed to safely transfer two (R1, R3) of three residents reviewed for accidents and assistive devices in the sample of three.

Findings include:

A. The Physician Order Sheet dated June 2015 for R3 documents the following diagnoses: Infection Post Traumatic Wound, Varicose Veins, Lymphadema, Anxiety, Muscle Weakness and Pain.

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The Minimum Data Set (MDS) dated 12/19/14 documents R3 as cognitively intact. This same MDS documents that R3 is an extensive assist of two and uses a wheelchair for mobility purposes.

Facility Nursing Notes document that on 1/26/15, R3 was transported to a physician appointment via facility van. R3 sustained a laceration while on the facility van to the right leg and was taken to the emergency room. R3 required 21 sutures to close the wound.

The facility report titled "Final Report" dated 1/27/15 documents that on 1/26/15, R3 was transported to a physician appointment by facility van. The report documents that E5, Van Driver did not properly secure R3's wheelchair in the van when returning from R3's physician appointment. R3's unsecured wheelchair rolled forward and R3 bumped R3's right leg on a bolt on the back of a seat causing a laceration. E5 turned the van around and took R3 to the Emergency Room for evaluation and treatment and notified the facility.

The Emergency Department records dated 1/26/15 for R3 document the following assessment and treatment: "There is a complex laceration located over the right shin which is 12 centimeters in length.....wound prepared and cleaned, wound edges are ragged, runs in an angled orientation ....skin closed with 21 sutures of 4-0 nylon....wound closed and approximated as best as possible, small (one centimeter) area in center unable to be closed due to sutures tearing through skin. (Two) steri strips applied to this area."

An untitled facility report dated 1/27/15 documents that "(E5) failed to properly secure

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(R3) during transport from a doctors appointment. This resulted in resident skin tear.....(E5) is cautioned to adhere to all facility policies and procedures with particular emphasis on safety." This report is signed by E16, Regional Clinical Consultant.

The facility policy titled "Vehicle Safety Policy and Procedure Manual" directs van operators as follows: "Seat belts, shoulder harnesses and wheelchair restraints (occupant restraint systems) shall be worn or used whenever the vehicle is in operation. The vehicle may not move until all passengers have fastened their restraints."

On 6/23/15 at 2:30 pm E5 Van Driver stated "I spaced out. I put (R3) in the van and I just forgot to secure the wheelchair. I did not lock the wheelchair or strap it in. When we went around the corner (R3) rolled forward and hit (R3's) right leg on the metal back of the seat. There was blood everywhere. I turned into the Emergency Room and two aids came and took (R3) in. I almost lost my job over this. I made a big mistake."

On 6/24/15 at 3:15 pm E13, Regional Administrator acknowledged facility failure and stated "We expected an investigation."

B.1.) The Physician Order Sheet dated June 2015 for R3 documents the following diagnoses: Infection Post Traumatic Wound, Varicose Veins, Lymphadema, Anxiety, Muscle Weakness and Pain.

The Minimum Data Set (MDS) dated 3/17/15 documents R3 as mildly cognitively impaired. This same MDS documents that R3 is totally dependent with two assist in transfers and uses a

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S9999	Continued From page 4 wheelchair for mobility purposes. The facility Fall Risk assessment tool documents that on 1/16/15, 5/4/15 and 6/5/15, R3 is at high risk for falls. A facility report titled "Occurrence Report" dated 1/22/15 documents that R3 was being transferred from the commode to R3's wheelchair when R3's legs gave out. R3 was lowered to the floor, receiving a skin tear to the right arm. The post fall intervention documented is that R3 is to be a mechanical lift transfer only. The report is signed by E14, former Director of Nursing. R3's Plan of Care updated on 1/23/15 documents that R3 is to be a two person assist with mechanical lift for all transfers. On 5/4/15 Nursing Notes document that R3 was again lowered to the floor by two Certified Nursing Assistants (CNA's), E11 and E12 while toileting R3 on the commode. R3's legs gave out from under R3. When R3 was lifted from the floor R3 received two skin tears, one on each upper arm. The facility report titled "Fall Occurrence Investigation Report" dated 5/4/15 documents R3 was lowered to the floor by CNA's while being transferred from a chair to the commode. Physical Therapy Notes dated 4/9/15 to 5/11/15 document the following: "(R3) continues to have functional deficits including unsteadiness, decreased activity tolerance and deficit balance recovery....." On 6/24/15 at 2:15 pm Z1, Physical Therapy Coordinator stated R3 was declining during this time period of 4/15 through 5/11/15 and was	S9999		

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S9999	Continued From page 5 assessed as a mechanical lift transfer due to her leg weakness and general decline. On 6/24/15 at 2:30 pm E8, Care Plan and MDS coordinator stated "(R3) has been a (mechanical lift) transfer for a long time The staff know this. (R3) has been a (mechanical lift), I know since January." 2.) The Physician Order Sheet dated June 2015 for R3 documents the following diagnoses: Infection Post Traumatic Wound, Varicose Veins, Lymphadema, Anxiety, Muscle Weakness and Pain. The Minimum Data Set (MDS) dated 3/17/15 documents R3 as mildly cognitively impaired. This same MDS documents that R3 is totally dependent with two assist in transfers and uses a wheelchair for mobility purposes. The facility Fall Risk assessment tool documents that on 1/16/15, 5/4/15 and 6/5/15, R3 is at High Risk for falls. R3's Plan of Care dated January 2015 through May 2015 documents that R3 is a two person assist with mechanical lift for all transfers. Nursing Notes for 6/9/15 document that staff used a mechanical lift to get R3 up from bed. During the transfer, the lift bumped into R3's glasses causing bruising beneath R3's eye. A facility report titled "Occurrence Report" dated 6/9/15 documents the following: E15, Certified Nursing Assistant was taking R3 off the mechanical lift and the lift slipped and hit R3's glasses causing bruising on R3's cheek and under eye.	S9999		

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On 6/24/15 at 11:40 am E2, Director of Nursing stated "there should have been two CNA's using the (mechanical lift) on (R3)." On 6/25/15 at 9:00 am E2 was going over the facility policy titled "Lifting Machine, Using a Portable" and stated that the policy documents that one CNA can operate the lift if the resident is able to participate. E2 stated "I guess we need to change that." E2 acknowledged that R3's Plan of Care documents that two staff members are needed for assistance when using the mechanical lift.

3.) R1's face sheet lists the following Diagnoses: Weakness and Dementia. R1's MDS dated 6/1/14 and 3/12/15 documents R1 requires extensive assist of two for transfers. R1's Careplan dated 2/3/15 documents R1 "requires extensive assist of two with bed mobility and a {full weight bearing}mechanical lift for transfers, toileting..."

An Occurrence Report for R1 dated 2/5/15 documents, "alarm sounding...(R1) was noted to be lying on her right side...asked CNA if she used a gait belt, CNA stated no, CNA stated that she lowered (R1) to the floor."

Progress Notes dated 2/5/15 documents, "(E9 CNA) stood (R1), just as (E9) had (R1) place buttocks on shower chair, (R1) went to sit and slid off shower chair, (E9) guided (R1) to the floor."

On 6/24/15 at 10:40 am E7 Restorative CNA confirmed that R1 was an extensive assist of two at the time of the 2/5/15 Occurrence. E7 stated R1 should not have been transferred with just one staff. E7 stated, "(R1) had been a two person assist, with a gait belt but due to her recent decline at that point, she had been changed to

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S9999	Continued From page 7 use a {partial weight bearing} mechanical lift to help her stand, after this fall is when she was made a {full weight bearing} lift." On 6/24/15 at 10:45 am when questioned about the careplan dated 2/3/15 documenting that R1 was a {full weight bearing} mechanical lift, E8 Care Plan Coordinator stated, "I changed her to a full mechanical lift after that incident, but I didn't added it as a new intervention, I just added it under the problem area, that is why the date is off, but (R1) was a {partial mechanical lift} at the time of the incident." (B)	S9999		