

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6007413	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/04/2018
NAME OF PROVIDER OR SUPPLIER PINE ACRES REHAB & LIVING CTR		STREET ADDRESS, CITY, STATE, ZIP CODE 1212 SOUTH SECOND STREET DEKALB, IL 60115		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

04/20/18

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S9999	Continued From page 1 resident to meet the total nursing and personal care needs of the resident. 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. (A, B) (Section 2-107 of the Act) These Requirements are not met as evidenced by:	S9999		

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S9999	Continued From page 2 Based on observation, interview, and record review the facility failed to ensure a resident requiring assistance was safely transferred from her wheelchair to her bed with the use of a gait belt to prevent resident injury. This failure resulted in R2 sustaining a large hematoma to her right chest, extensive bruising across her chest and both breasts on April 1, 2018, and requiring hospitalization on April 3, 2018. The facility also failed to ensure staff use the mechanical lift safely when transferring residents to prevent resident's from receiving bruises. This applies to 4 of 5 residents(R2, R3, R4, R5) reviewed for safety in the sample of 5. The findings include: 1. R2's Electronic Medical Record (EMR) accessed on April 4, 2018 shows that R2 has diagnoses including Parkinson's Disease, Alzheimer's Disease, and Paranoid Schizophrenia. The EMR also shows that R2 has severe cognitive impairment and requires extensive assist of two staff for transfers. R2's Progress Notes dated April 3, 2018 state, "During the nurse's assessment, purple bruising to right upper chest noted, traveling to left chest, raised area to right chest noted, 13cm long x 5cm raised, warm to touch. Swelling to right hand, swelling noted around digits 2 through 4. Resident stated she is unaware of how this occurred." Resident sent to the ER for further evaluation. The hospital consult note dated April 4, 2018 written by V7(Nurse Practitioner) states, "She has	S9999			

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S9999	Continued From page 3 extensive bruising noted to her bilateral breasts, purplish in color to underneath her breast tissue, but yellowed in color to her right upper chest wall. These appear to be older bruising. She is with a cast/splint to her right arm and in a sling, due to a right distal radius fracture, and a closed non-displaced fracture of third metacarpal bone of right hand." On April 4, 2018 V7 stated, "{R2} had bruising to her right upper chest that was yellowed. The fractures are a concern also but I did not review the X-rays or the X-ray reports. Generally bruises are bright purple for many days before they turn yellow. She has no history of a blood coagulation problem. It looks like someone "bear-hugged" her. I heard that the facility had no idea how it happened. It was extensive enough that I felt social services should be involved. It looked like an elder abuse case." The hospital X-ray report of R2's Right hand dated April 3, 2018 shows, "Suspected age-indeterminate fractures versus areas of degenerative change seen at the head of the third metacarpal and distal radius." On April 4, 2018 at 9:15AM, V2(Director of Nursing) stated, "On Monday(April 2, 2018) I was asked to assess {R2} because she had a hard lump on her right side, kind of under her arm. It was a hard mass. There was slight bruising under the mass. We called the doctor and he ordered blood work STAT. We got the results and faxed them to him but he didn't really do anything. Then on Tuesday morning {R2} had bruising from one arm to the other (across chest). We called the doctor and he said to send her to the ER. They admitted her last night for pneumonia. We looked at the schedule and talked to the nurse from	S9999		

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S9999	Continued From page 4 Sunday night. He worked a double shift and the mass wasn't there at the start of his shift but it was there on Monday morning. Since {R2} doesn't transfer out of her bed on night shift we narrowed it down to PM shift on Sunday night. We found that a new CNA transferred {R2} without a gait belt and her preceptor just watched her do it. {V3- Assistant Director of Nursing} is doing the investigation." On April 4, 2018 at 9:45AM V3 stated, "I called seven staff that worked 2nd shift on Sunday. {V8-CNA-Certified Nursing Assistant} was training {V9-CNA}. {V8} watched {V9} care for {R2}. {V8} said she didn't think {V9} used a gait belt to transfer her. {R2} requires extensive assist of one staff and {V9} bear-hugged her and transferred her. I have not talked to {V9} yet." On April 4, 2018 at 1:05PM V8 stated, "I was orienting a new CNA, {V9}. I was standing in the room, {V9} transferred {R2} to the bed. {V9} was on her left side, she hooked her under one arm and grabbed the back of her pants. She did not use a gait belt." On April 4, 2018 V3 provided surveyor with a written copy of her interview with V9. At 3:00PM V9 stated to V3, "On April 1, 2018 {V8} watched me transfer {R2}. I held on to her britches and under her arm to transfer her." R2's care plan dated January 13, 2016 states, "Provide extensive assist of one with FWW(Front Wheeled Walker) for transfers. Utilize gait belt at all times." The facility policy entitled Gait Belt Usage Policy dated 8/20/2016 states, "Residents that require hands on and stand by assist with transfers and	S9999		

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S9999	Continued From page 5 ambulation will have gait belts used as part of the process. Purpose: To provide safety and protection during the transfer process." 2. The incident report for R3 dated March 20, 2018 states, "Resident has a bruise to her right shoulder. This may have occurred when the staff (mechanically lifted) her into bed. The (mechanical lift) may have landed on her shoulder." The incident report for R4 dated March 27, 2018 shows that R4 has a pink raised area on her right forehead. The incident report states, "She may have hit her head on the (mechanical lift)." The incident report for R5 dated March 29, 2018 shows that R5 has 4 small bruises on her right lower arm and a bruise on the back of her left hand. The incident report states, "She could have bumped arm in the wheelchair during a transfer or on the (mechanical lift)." On April 4, 2018 at 3:45PM V3(Assistant Director of Nursing) stated she was not sure why so many residents were developing bruises related to the mechanical lift. On April 4, 2018 at 4:00PM, V2 and V3 (Director of Nursing and Assistant Director of Nursing) confirmed that they are aware that the facility has had some issues with transfers and they are in the process of setting up a skills training for the CNAs." The facility policy entitled Hoyer (mechanical lift) Transfer dated February 24, 2018 states, "Using a hydraulic lift to raise the immobile resident from the supine to the sitting position allows safe, comfortable transfer between bed and chair."	S9999		

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