

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6014120	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/29/2018
NAME OF PROVIDER OR SUPPLIER ILLINOIS VETERANS HOME - ANNA		STREET ADDRESS, CITY, STATE, ZIP CODE 792 NORTH MAIN ANNA, IL 62906		
(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
S 000	Initial Comments Complaint Investigation # 1853385 / IL102885	S 000		
S9999	Final Observations Statement of Licensure Violations 340.1505c) 340.1505g) Section 340.1505 Medical, Nursing and Restorative Services c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. g) All necessary precautions shall be taken to assure that the resident's 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. This regulation is not met as evidenced by: Based on observation, interview and record review the facility failed to prevent an injury during a mechanical lift transfer for 1 of 3 residents (R3) reviewed for mechanical lift transfers in a sample of 4. The findings include: R3's Annual Minimum Data Sets (MDS) assessment dated March 27, 2018 for R3 lists the following: a Brief Interview for Mental Status (BIMS) score of 13 indicating R3 is cognitively	S9999		

Attachment A
Statement of Licensure Violations

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

TITLE

(X6) DATE

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S9999	Continued From page 1 intact. Activities of daily living self performance as totally dependent (full staff performance every time) with two persons physical assistance for transfers, toilet use and bathing. Balance during transitions and walking is coded as only able to stabilize with staff assistance with transfer between bed and chair or wheel chair with range of motion limits of impairment on upper and lower extremities both sides. R3's height is 61 inches and weighs 214 pounds. The care area assessment summary document specifies activities of daily living (ADL) functional/rehabilitation potential as being triggered due to needing assistant with all ADLs. R3's care plan with a date initiated of May 29, 2015 lists a focus area "(R3) has an ADL self-care performance deficit r/t (related to) diagnosis of multiple sclerosis." R3's care plan documents an intervention dated 5/29/15 of "TRANSFERS: Staff assist of 2 with mechanical lift with transfers. (Hoyer)" On the same Care Plan under another focus area of "(R3) is at risk for falls r/t multiple sclerosis and impaired mobility" under interventions "(R3) requires assist of 2 with transfers using a lift." A progress note dated May 11, 2018 for R3 states "Vnac (Veterans Nursing Assistant) went to resident's room to get (R3) up for supper. A second Vnac was to assist but was not in the room yet. First Vnac fastened (R3) onto the lift and proceeded to get (R3) up when the lift tipped and the bar hit (R3) in (R3's) face. (R3) has a small laceration on the bridge of (R3's) nose and a scrape on (R3's) forehead. (R3) denies any pain. Second Vnac arrived at the room and together they got (R3) up into (R3's) w/c (wheelchair). (R3) was brought to the nurses station and wounds were treated. (R3) told me	S9999			

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S9999	Continued From page 2 (R3) was okay. (R3) was taken to the dining room and assisted with supper. This nurse called the DR. (doctor) at 1800 (6:00 PM), message left; Management notified at 1815 (6:15 PM) and this nurse called the POA (power of attorney for healthcare) at 1820 (6:20 PM) but received no answer. Message left" and was signed by V3. A document entitled "Unusual Occurrence Checklist" signed by V2, Director of Nursing and V1, Administrator dated May 11, 2018 under "Final Investigation and Comprehensive Analysis of unusual Occurrence" states the following: "On May 11, 2018 at 1925 (7:25 PM) R4, Certified Nurses Aide (CNA) entered R3's room to assist (R3) out of bed for supper. She assisted (R3) without staff assist. She fastened R3 into the lift and proceeded to get (R3) out of bed when the lift tipped and the cross bar hit R3 on (R3's) face. She immediately notified the charge RN (V3)." The Investigative summary on the same document states "the second CNA (V5) entered room and V4 and V5 proceeded to transport R3 to (R3's) wheelchair. V3 performed an assessment checking for injury, laceration noted on the bridge of nose and an abrasion to forehead. First Aid applied at the nurses desk...Staff educated regarding proper techniques while assisting members into bed and while assisting members in and out of bed with the lift, including appropriate lift use with two staff members." A witness interview form from an investigation for R3's head injury dated May 11, 2018 signed by V4 states under 'Narrative Statement' "I was in there and hooked R3 up and proceeded lifting to (R3's) chair and lift tipped and fell and hit (R3) in the head." Another witness interview form signed by V5 states "I wasn't in the room she (V4) had	S9999			

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ILLINOIS VETERANS HOME - ANNA

**792 NORTH MAIN
ANNA, IL 62906**

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S9999	Continued From page 3 asked another CNA to help, they weren't in there so I assisted her finishing getting (R3) unhooked." On May 29, 2018 at 10:27 AM, R3 stated when asked what happened when the lift hit R3 in the head "It just gave out" and reports getting "a few scratches on my head." R3 requested to talk about something else and did not want to discuss the incident. On May 29, 2018 at 1:01 PM, V4 stated "I was by myself. I came in, dressed (R3) and hooked up the Hoyer (mechanical lift) as usual. My back was to the door and the Hoyer was on the side of the wheelchair with the Hoyer lift legs under the wheelchair. I had control box of the Hoyer lift in my hand. I should have waited on someone else but I didn't and I used the control box to start lifting (R3) when the top bar of the lift tipped over and hit (R3) on the top of (R3's) head. I tried to catch it but I couldn't. Just as it tipped and struck (R3), (V5) came into the room... I have had training on Hoyer lift transfers." On May 29, 2018 at 2:48 PM, V5 stated not being in the room when the lift struck R3 and when she (V5) entered the room, R3 "was in the wheelchair and V4 told me the bar that the hooks attached to the lift with tipped, and got (R3) in the head and nose." On May 29, 2018 at 3:30 PM V3, stated V4 "went to get R3 up and (V4) knows there has to be two and she chose not to wait, and when she went to lower (R3) to the chair the bar (not sure which one) hit (R3) in the face. The injury was a scrape on (R3's) right side of forehead, and a small place on (R3's) cheek. V4 was crying, she knows she had messed up. It's mandatory when you use a Hoyer lift you have to use two. She's capable and	S9999		

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S9999	Continued From page 4 I'm sure she thought she could do it by herself, but you need two one to guide them to the chair and the other to work the controls." The User Manual for the mechanical lift used to transfer R3 from the bed to a wheelchair on page 8 under Operating the lift warning "Although (formal name of lift company) recommends that two assistants be used for all lifting preparation, transferring from and transferring to procedures, our equipment will permit proper operation by one assistant. The use of one assistant is based on the evaluation of the health care professional for each individual case." Page 24 of this same document entitled "Lifting the Patient" under the title "Positioning the patient lift WARNING states "The legs of the lift must be in the maximum open position for optimum stability and safety. If it is necessary to close the legs of the lift to maneuver the lift under a bed, close the legs of the lift only as long as it takes to position the lift over the patient and lift the patient off the surface of the bed. When the legs of the lift are no longer under the bed, return steles of the lift to the maximum open position and lock the shifter handle immediately." Page 31 of this same document under "Transferring to a Wheelchair" number 8 states "Two assistants are recommended for this step - One assistant stands behind the chair and the other operates the patient lift. The assistant behind the chair pulls back on the grab handle (on select models) or sides of the sling to seat the patient well into the back of the chair. This will maintain a good center of balance and prevent the chair from tipping forward." A facility Nursing Policy and Procedure entitled "Mechanical Lifting Devices" revised March 3, 2017 for Total Lift states "The patient is non-ambulatory...or physically unable to provide	S9999			

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S9999	Continued From page 5 assistance with the transfer...A total lift transfer will take the assistance of two direct care staff. *Full Mechanical Lift required." "C"	S9999			