

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 03/01/2018
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	S9999	Attachment A Statement of Licensure Violations		

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

03/16/18

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 03/01/2018
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	Continued From page 1 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, 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	S9999			

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 03/01/2018
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	Continued From page 2 by: Based on observation, interview, and record review the facility failed to provide a safe transfer for a resident. This resulted in R1 sustaining a fracture to her left humerus and bruising to R1's left shoulder, arm, hand, and knee. This applies to 1 of 3 residents (R1) reviewed for transfers in the sample of 6. The findings include: R1's Admission Assessment Record dated February 17, 2018 shows R1 is alert and oriented x 3, readily able to answer questions, and quick comprehension. The same assessment also shows R1 requires staff assistance of two with a walker for transfers. The assessment record shows diagnoses including muscle weakness, cellulitis of the right leg, heart failure, hypertension, chronic pain syndrome, and left eye blindness. R1's Incident Report dated February 21, 2018 shows R1 sustained a fracture during a transfer. R1's radiology report dated February 22, 2018 shows: "There is andisplaced fracture involving the left humeral neck (upper left arm)" On February 27, 2018 at 10:00 AM, V17 (CNA) transferred R1 into bed and provided her a bed pan. A purple-black grapefruit size bruise was observed on her lateral (outer edge) of her left knee. R1's left hand had dark purple bruising	S9999			

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 03/01/2018
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	Continued From page 3 covering the top of it. R1's left arm was covered with a night gown and could not be viewed by this surveyor. V17 said she had no idea what the bruising was from and it's been there awhile I think. On February 27, 2018 at 12:45 PM, V2 said R1 did not have any left knee bruising prior to the February 21, 2018 incident. V2 said she did not realize R1 was experiencing arm and knee bruising. V2 said the bruising had not been reported by nursing staff. On February 27, 2018 at 8:30 AM, V2 (DON-Director of Nurses) stated R1 was transferred from her wheelchair to the bed on February 21, 2018 by V4 and V16 (CNAs-Certified Nurse Aides). V2 said she did not witness the transfer but interviewed the CNAs days after the transfer. V2 stated both CNAs said R1 was pressing against them with her arms during the transfer and they heard a "pop" sound near R1's arms. At 12:45 PM, V2 said after interviewing V4 and V16 she determined that R1 sustained a left shoulder fracture on February 21, 2018 because "it was a bad transfer." On February 27, 2018 at 9:25 AM, R1 stated she was lifted out of her wheelchair by two aides a few days ago. R1 was unable to recall who the aides were but said "they used my arm to lift me when I was standing next to the bed." R1 said she heard a sound "like fingers snapping." R1 said, "They held me by my arm right here," and pointed to her left upper arm. On February 27, 2018 at 10:00 AM, V17 and V18 (CNAs) said residents should never be held or grabbed by the arms. V17 said a gait belt should be used to stabilize residents during a transfer.	S9999			

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 03/01/2018
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	Continued From page 4 V18 said residents should never be lifted by the arms or held by the arms. V18 stated that could cause a pulled muscle, bone dislocation, or bone fracture. On February 27 2018 at 11:05 AM, V4 (CNA) stated she did assist V16 when transferring R1 out of the wheelchair and into her bed on February 21, 2018. V4 said R1 gets very nervous at every transfer and tends to push up against us with her arms. V4 said R1 was pushing and resisting during the transfer when she heard a sound like a crack. V4 said it sounded "like her arm had cracked, like knuckles cracking." On February 27, 2018 the facility attempted to reach V16 (CNA) by telephone. This surveyor also telephoned V16 on February 27 and left three call back messages at 11:00 AM, 1:30 PM, and 3:40 PM. V16 was scheduled to work the evening shift on February 27. V16 did not show up for her shift or return phone messages during this survey. On February 27, 2018 at 2:20 PM, V7 (Registered Nurse) said if a resident is resisting a transfer aides should stop and re-approach the resident later. At 2:40 PM, V3 (Assistant Director of Nurses) said aides should not force a transfer if the resident is pushing or resisting. Aides should find additional staff to re-approach the resident with a new face. R1's February 2018 progress notes show entries pertaining to bruising on several entries beginning on February 22nd (9:40 PM) -Call received from (R1's physician) inquiring on resident's incident of fractured humerus and bruise on the left knee measuring 10x6 centimeters. On February 24th (1:39 PM)-left shoulder bruised, left hand is	S9999			

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 03/01/2018
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	Continued From page 5 bruising now, anterior left knee bruised. On February 24 (2:02 PM)-Dark purple bruising continues to left upper arm down through hand. On February 25 (8:55 AM)-Bruising continues to left shoulder down to left hand. On February 25 (2:07 PM) Bruising remains to left shoulder and left hand. Bruising to left knee remains. The facility's Restorative Nursing Transfer Program policy updated on August 20, 2016 states under the education section: "3. If at any time during the transfer process a resident resists, is not participating safely, or unable to participate safely, the transfer is stopped and the resident is returned to a safe position then the nurse is notified." (B)	S9999			