Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6016737	A. BUILDING: _____ B. WING _____	03/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCY CIRCLE	3659 WEST 99TH STREET CHICAGO, IL 60655

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S9999	Final Observations Statement of Licensure Violation: 1 of 1 Violation 300.1210a) 300.1210b)5) 300.1210d)6) 300.1220b)3) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological	S9999	Attachment A Statement of Licensure Violations	

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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, 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 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

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3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

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:

Based on interview and record review the facility failed to use appropriate transfer techniques and develop effective interventions for two residents (R15 and R17) reviewed for falls in the sample of twelve. These failures resulted in R15 falling and sustaining a torn quadriceps tendon and fractured toe; and R17 falling and sustaining an arm laceration.

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Findings include:

3/13/18 1:58 PM R15 stated that I had a fall because a gait belt was not used. I had a split tendon and a broken toe.

3/15/18 10:30 AM V1 (DON-Director of Nursing) stated that there was no gait belt used to transfer R15 (on 2/14/18). V1 stated that a gait belt should be used for all transfers, and there should have been two staff assisting in the transfer. There was only (V5).

3/15/18 11:10 AM V5 (CNA-Certified Nursing Assistant) stated that (R15) was going from the bed to the chair. (R15) was an inch from the chair and said my knees are buckling. (R15) went down on (R15's) knees. There was no gait belt used. The gait belt was not in the room. I had totally forgotten. I knew her to be one assist.

The MDS (Minimum Data Sheet) dated 2/8/18 is coded for extensive assistance for transfers with two plus person physical assist.

An untitled document reads: Problem/Violation: On 2/14/18 Resident 1 was being assisted out of bed into a chair to have her linen changed. Staff 1 failed to use a gait belt during the transfer which resulted in Resident 1 falling to her knees after (Resident 1's) right knee gave out.

A progress note dated 2/14/18 9:17 AM by V12 (Physician) reads; (R15) had a fall morning of 2/14 at SNF (Skilled Nursing Facility) while care partner was attempting to help (R15) transition from bed to a chair, complained of severe mostly right-sided pain especially in (R15's) foot.

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A progress note dated 2/14/18 9:36 AM by V13 (Registered Nurse) reads; during ambulation, resident stated that (R15's) knees buckled and (R15) fell backward.

A progress note from the hospital dated 2/16/18 reads; Right Quadriceps tendon rupture and fracture right great toe.

3/14/18 1:15pm R17 stated sometimes his bed is lowered to the lowest position when he is in it, at other times it is not. V10 (family member) is unaware of bed being used in a low position and has never seen R17 in bed in a low position.

3/14/18 2:25pm V7 (CNA-Certified Nursing Assistant) stated that R17 "is monitored every 15-20 minutes when he is in his room".

3/14/18 2:25pm V8 (CNA) stated "R17 slides in the wheelchair a lot. The star on the door shows he is at risk for falls and the picture shows it."

3/14/18 3:09 V8 was observed to be pushing R17 in his wheel chair in the hall and R17 was leaning to his right side. The back of the wheelchair was reclined back and the wheelchair foot pedals were in place.

3/15/18 11:07am
V11 (CNA) reports she regularly cares for R17. V11 showed surveyor the computer system used for charting. On review the computer system did not list any care needs related to using a dycem, lowering R17s bed to the floor or the need for a star on the door to indicate a fall risk. V11 states "I don't see any specific care needs updated" for R17 in computer system. V11 stated "I have never attended a care plan meeting, they are not

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S9999	Continued From page 5 for us." 3/15/18 12:25pm Interview with V9 (RN and MDS Coordinator) at nurses' station. V9 stated when a fall occurs she is notified and she completes "a full investigation and an intervention will be done immediately." V9 stated if she is not in the facility "The review waits until I'm here." V9 (RN) stated the Interdisciplinary Team (IDT) reviews falls and discusses the interventions "the next morning in morning meeting. The interventions are communicated to staff verbally by 24 hour reports and stand up meetings." According to V9 she is responsible to add the new interventions to the care plan and CNA computer program. In discussing the fall of R17 on 12/29/17 V9 stated "must have been a weekend. Definitely, no intervention in place." V9 stated she adds fall interventions to the care plan "immediately, when I'm on." Record review shows R17 fell on 12/29/17, 12/31/17, and 1/6/18. V9 stated she was "not sure what else to do" in adding interventions to prevent falls. V9 stated there is no documentation to show that staff checked R17 every 15-20 minutes as stated by V7 or at increased times as indicated in the care plan. Per record review: 10/17/17 R17 had a fall with no injury. Intervention: do not leave walker in reach when unsupervised, increase rounds, remind to ask for assistance, and increase rounds when in bed. 11/12/17 R17 had a Fall with no injury. Intervention: encouraged to call for assist, pink reminder signs in room "ask for assistance, " sticky on recliner chair, and restorative programs. 12/29/17 R17 slid out of wheelchair no injury. Intervention: leg rests and position properly with	S9999		

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S9999	Continued From page 6 butt back in wheelchair. 12/31/17 R17 on floor in bathroom. R17 sent to hospital for evaluation. Record review notes the facility received a call stating "resident loss consciousness "during hospital transfer. R17 was hospitalized from 12/31/17 until 1/5/18 until he returned to facility. Diagnosis listed on face sheet dated 1/5/18 is "Non-traumatic Intracranial Hemorrhage, unspecified." 1/6/18 R17 slipped out of wheelchair no injury. Intervention: educate to call for assistance, sticky to wheelchair. 2/23/18 R17 had fall in bathroom and obtained laceration to right arm. Intervention: brightly colored signs placed in key areas in R17's room to remind him to ask for assistance. Re-educate R17 to call for assistance. (B)	S9999		