STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001184	A. BUILDING: _____ B. WING _____	C 07/10/2018

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BRITISH HOME, THE	8700 WEST 31ST STREET BROOKFIELD, IL 60513

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S 000	Initial Comments Complaint Investigation 1893947/IL103479 F689 F600	S 000		
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 which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a 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**	

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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:

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. (Section 2-107 of the Act)

These Regulations were not met as evidenced by:

Based on interview and record review, 1) the facility neglected to ensure that all certified nurse aide staff were trained on the safe use of the mechanical lift/Sit to Stand lift and neglected to follow the facility Policy, Safe Lifting and Movement for the use of the mechanical lift for 1 resident R2, reviewed for falls/safety.

2) the facility failed to follow the MDS (Minimum Data Set) for a 2 person assist with transfers

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using the mechanical lift, and the plan of care interventions of (2) person assist with transfers while utilizing the mechanical lift for one resident (R2) reviewed for safe transfer.

These failures resulted in R2 falling and being evaluated in the local hospital and assessed to have a right femur fracture requiring surgery. R2 had a difficult course after femur fracture repair, R2 expired, V15 MD (Medical Doctor) Hospitalist stated, " R2's death was caused indirectly from the femur fracture."

Finding Include:

R2 was an 85 year old with diagnoses that include, but not limited to hypertension, atrial fibrillation, diabetes mellitus type 2, anemia and low back pain. R2 was hospitalized on 4/28/18 for a femur fracture.

The facility Incident Report for R2 dated 4/27/18 at 6:10 PM documents CNA (Certified Nursing Assistant, V6) finished giving patient shower, was transferred from shower chair with sit to stand when patient started slipping and was lowered to the floor. Having extreme pain of right knee. Staff assisted patient from floor with mechanical lift into bed. Medicated with Tylenol for comfort, vital signs in normal range. Call doc (Medical Doctor) V13, ice to affected area.

Final Report to IDPH (Illinois Department of Public Health) RE: R2 On Friday April 27, 2018 at 6:10 PM agency CNA V6 called for assistance from shower room. Nurse and another CNA arrived in shower room to find R2 sitting on the floor dressed in a gown with R2's trunk supported by the CNA and R2's feet on the base of the sit to stand (device). During assessment the resident

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complained of right knee pain. Per agency CNA, the resident was being transferred from shower chair to wheelchair when resident slid to floor. Nurse notified physician who ordered STAT (immediate) x-ray of right knee. Right knee Xray received early morning which indicated an acute distal femur osteoporitic fracture with lateral displacement. Result related (relayed) to physician who ordered R2 be sent out to the hospital. R2's POA (Power of Attorney) notified. While at the hospital R2 underwent ORIF for femur fracture.

On 7/5/18 at 1:30 PM, via telephone, Agency CNA V6 stated, " I was working with R2, I gave R2 a shower. I applied sling under arms. R2 had a bowel movement in the shower, I wanted to clean R2 up before R2 sat down. R2 was on the sit to stand and I was wiping R2. R2 slowly slid out of the sling under R2's arms. I called for help, I put my body against R2 to support R2. When help came, R2 was already on the floor. I knew R2 can't stand to long, I believe it was under two minutes R2 was in the sling. I was alone during the transfer. R2 didn't say anything until R2was on the floor, then complained of right leg pain. I did the same thing with R2 the prior week with no problems. The nurse assessed R2 while on the floor. It happened around 6:00 PM.

On 7/6/18 at 1:10 PM V14 RN (Registered Nurse) stated, "Someone called for help, the ADON V3 (Assistant Director Of Nursing) was already there. R2 was on the floor, vitals were normal, complained of pain and being cold. We put a blanket on R2. We brought R2 back to the bed. I called the doctor, who ordered a STAT x-ray. I gave R2 Tylenol. I believe it was V16 RN who I endorsed it to. I was leaving around 8:00 PM. I still don't understand how it happened.

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On 7/6/18 at 2:15 PM, V16 RN stated that the x-ray technician came around 12:00 AM. R2 was calm, said the leg hurt. I gave Tylenol. When I got the x-ray results I called the doctor and the doctor ordered R2 be sent out to the hospital. We sent her out around 2:00 AM.

The radiology report for R2 dated 4/28/18 documents; Right knee, Acute distal femur osteoporotic fracture.

On 7/3/18 at 12:45 PM V2 DON (Director of Nursing) stated, " Concerning ADL (Activities of Daily Living) assessments, if the resident is in PT (Physical Therapy) they do the ADL assessment, if not in therapy, the nurses do it. They do a judgement call for the assessment. The CNA (Certified Nursing Assistant) involved was from an agency. I assume she was trained on a sit to stand device by the agency. I have spoken with her and she seemed to understand. I have not trained her here and have not seen a demonstration using the sit to stand with her. After this incident with R2 we changed our policy and procedure to a two person assist with the sit to stand."

On 7/5/18 at 11:30 via telephone V10 Agency Representative stated, " V6 met her competency requirements for fall prevention, however, V6 was not trained here (Agency) on the sit to stand device."

On 7/6/18 at 9:20 AM V9 PTA Physical Therapy Assistant stated that for the sit to stand, we would use the Standing Static Goal Status. For R2 the progress summary states R2 could stand one minute. This is R2's last therapy treatment, R2 met most of her/his goals and was discharged

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(from PT) on 3/15/18.

The PT Therapist Progress and Discharge Summary dated 3/15/18 for R2 documents; End of Goal Status as of 3/15/18 Goal Met on 3/16/18 able to maintain balance with handheld support and constant contact guard assist for less than 1 minute.

On 7/6/18 at 12:30 PM via telephone V15 MD (Medical Doctor) Hospitalist stated, " R2's death was caused indirectly from the femur fracture. I took care of R2 toward the end, R2 was in hospice and I am the physician on record for R2's death certificate. After R2's surgery for the fractured femur repair, R2 was unable to be extubated and was put on a ventilator and put in ICU (Intensive Care Unit). We got R2 off the ventilator, but at some point, R2 got a liver injury (shocked liver), R2's electrolytes were hard to control and R2 also suffered a kidney injury. I'm not sure how these conditions occurred. R2 had a very complicated course after the femur repair surgery."

R2's Care Plan dated 2/19/18 documents; ADL Function/Rehab Potential. I require limited care for my bathing, grooming, dressing, mobility and set up for meals. I need extensive assist for transfers. A. I need 2 staff assist with the sit to stand device for transfers.

The facility policy titled, Safe Lifting and movement of Residents, dated December 2013, documents; In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents. 4. Staff responsible for direct resident care will be trained in the use of manual

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S9999	Continued From page 6 (gait/transfer belts, lateral boards) and mechanical lifting devices. 6. Staff will be observed for competency in using mechanical lifts and observed periodically for adherence to policies and procedures regarding use of equipment and safe lifting techniques. The MDS dated 3/15/18 Section G documents Transfers; total dependence full staff performance every time during entire 7 day period. Two plus persons physical assist. (B)	S9999		