

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000244	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/30/2018
NAME OF PROVIDER OR SUPPLIER HEARTLAND OF NORMAL			STREET ADDRESS, CITY, STATE, ZIP CODE 510 BROADWAY NORMAL, IL 61761		
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S 000	Initial Comments Incident Report Investigation to Incident of 5/7/2018 / IL102920	S 000			
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b))d)3)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 resident to meet the total nursing and personal	S9999			

Attachment A
Statement of Licensure Violations

Illinois Department of Public Health

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

TITLE

(X6) DATE

06/22/18

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S9999	Continued From page 1 care needs of the resident 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 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record 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 These Regulations are not met as evidenced by: Based on interview and record review the facility staff neglected to operationalize their policy on a safe mechanical lift transfer for one of three (R1) residents reviewed for transfer in a sample of 6. This resulted in R1 sustaining a spiral fracture of the right femur and failed to assess residents post fall of three of three residents (R1, R2 and R3) reviewed for falls in a sample of six. The facility failed to control a residents pain related to a fracture for one (R1) of three residents reviewed	S9999			

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S9999	Continued From page 2 for pain in a sample of six. This failure resulted in R1 experiencing unrelieved pain for twelve hours then subsequently being admitted to the hospital with a spiral fracture of the right femur. Findings: The facility Lifts and Injury-Reducing Devices manual dated September 2017 documents "A two person lift is required when using lift equipment. The facility policy Patient Protection Abuse, Neglect, Exploitation, Mistreatment and Misappropriation Prevention documents "Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental an anguish, or emotional distress." The facility incident report dated 5/7/2018 documents R1 was transferred on a sit to stand (mechanical) lift by V8 Certified Nurse Aide (CNA). R1 was sliding off the edge of the bed and subsequently fell with R1's foot caught under the sit to stand lift. R1's hospital x-ray dated 5/8/2018 at 9:44AM documents an oblique spiral fracture of the right femur with up to a 15 millimeter displacement of the distal fracture fragment. On 5/29/2018 at 9:50AM, V3 (Orthopedic Physician) stated "A spiral fracture requires a twisting motion with torque. I feel the injury occurred when (R1) was lowered to the floor and (R1's) foot caught on something, which created a twisting motion. A true pathological fracture has a tumor involved. (R1) had no tumor." On 5/29/2018 at 1:27PM, V8 stated "I used the sit to stand lift to transfer R1 from the wheelchair to bed by myself on 5/7/2018. (R1) slid off the bed onto the floor in a sitting position. I know I was to	S9999			

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S9999	Continued From page 3 have another staff person help me with all mechanical lift transfers, but I did the transfer by myself. V8's personal file has the Facility Lift Free document stating "Our policy is that there is always a two person lift even using mechanical lifts." Work rule critical /type A- Remember you must comply with all health and safety rules, including rules prohibiting unsafe conduct or unsafe acts which jeopardize the health and safety of self or others or results in serious injury." This document was signed by V8 and dated 4/20/2018. On 5/30/2018 at 12:05PM, V5 (CNA) stated "V8 attempted to transfer (R1) earlier in the shift by (V8's) self. V8 had (R1's) feet off the (sit to stand) lift platform with legs straddling the platform and (R1) hanging from the sling. I took two other CNA's in and retrained (V8) how to properly use the lift and reported this to the nurse (V6). On 5/29/2018 at 11:07AM, V6 (Nurse) stated "I remember (V5) telling me (V8) was transferring (R1) by (V8's) self and I heard (V6) re-educate (V8) how to properly utilize the sit to stand lift. I also reinforced with (V8) never to transfer a resident with a sit to stand or sling lift by (V8's) self, there always must be two staff present for (mechanical) lift transfers." On 5/29/2018 at 10:30AM, V1 (Administrator) stated "It is the facility policy that all mechanical lift transfers require a two person (staff) transfer. V8 was a new employee and only worked at the facility for about two weeks before this incident occurred and V8 resigned." a.) R1's facility face sheet dated 5/29/2018	S9999			

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S9999	Continued From page 4 documents a diagnosis of Right Hip Joint Prosthesis, Dysphasia, Hypertension, Iron deficiency Anemia. The Minimum Data Set dated 3/23/2018 documents R1 is cognitively intact requiring extensive assistance of two for transfers. The facility Incident Report dated 5/7/2018 at 11:20PM documents a "Certified Nurses Aide (V4) was attempting to put R1 to bed using a sit to stand mechanical lift. V8 Certified Nurse Aide stated V8 could only get R1 to the edge of the bed. R1's feet started to slide. R1's foot was caught in the sit to stand lift and R1 fell to the floor. R1 complained of pain on the inner right femur; later R1 complained of pain on the outer right femur. R1 was assisted to bed using a sling mechanical lift. Ice packs were applied to R1's thigh." On 5/29/2018 at 10:30AM, V1 (Administrator) verified R1 was transferred by V8 with the sit to stand lift alone. R1 is a two person sit to stand lift transfer." On 5/29/2018 at 11:07AM V6 (Nurse) stated "(V8, Certified Nurse Aide) came out of R1's room into the hallway yelling for help. When I entered (R1's) room (R1) was laying on the floor. (R1's) foot was caught under the sit to stand machine with the foot twisted to the side. I gently removed (R1's) foot from under the sit to stand. (R1) was complaining of pain in the outer thigh, trembling and shaking. (V8) per facility rule should never have transferred (R1) by (V8's) self. I notified the on-call Nurse Practitioner (not sure who it was) and also the family. " On 5/29/2018 at 12:05PM V5 (Certified Nurse	S9999			

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S9999	Continued From page 5 Aide, CNA) stated "when I entered (R1's) room after (V8) told me (R1) was sliding off the bed, (V6) nurse was in the room. (R1) was on the floor between the bed and the sit to stand machine leaning to the left cry out in pain. (V8) told me (V8) tried to transfer (R1) to bed by (V8's) self. I had already re-educated (V8) earlier in the shift on a proper sit to stand transfer and never to transfer a resident alone." On 5/29/2018 at 9:50AM, V3 (Orthopedic Physician) stated "A spiral fracture requires a twisting motion with torque. I feel the injury occurred when (R1) was lowered to the floor and (R1's) foot caught on something, which created a twisting motion. A true pathological fracture has a tumor involved. (R1) had no tumor." R1's hospital x-ray dated 5/8/2018 at 9:44AM documents an oblique spiral fracture of the right femur with up to a 15 millimeter displacement of the distal fracture fragment. The facility Lifts and Injury-Reducing Devices manual dated September 2017 documents "A two person lift is required when using lift equipment." b 1.) R1's facility incident report dated 5/7/2018 documents a lift transfer fall with a fractured right femur. R1's clinical record had no documented post fall assessment. On 5/30/2018 at 10:00AM, V3 (Assistant Director of Nursing) verified that the post fall assessment was not completed. V3 stated "I do the post fall assessments and I did not do one for this fall." 2.) R2's Facility incident reports documented the following information: dated 3/29/2018 at 3:00PM	S9999			

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S9999	Continued From page 6 - found on floor in a supine position with back of body up against the closet; 4/7/2018 at 7:30PM - Noted on floor of room injuries include a skin tear on elbow and abrasion on the knee; 4/21/2018 - Patient rolled self out of the bed onto the floor while bed was in the lowest position; and 5/26/2018 - resident on the floor, prior to the incident resident was in bed. Resident (R2) very confused, yelling for the police and combative with care, grabbing staff in the arm. R2's clinical record has no documented post fall assessment for the falls of 3/29/2018, 4/21/2018 or 5/26/2018. The assessment for the 4/21/2017 was completed on 4/27/2018 per V3 on 5/30/2018 at 10:00AM. V3 also verified the other two were not completed. 3.) R3's Facility incident reports dated 5/18/2018 documents the following information: 5/18/2018 - resident stated R3 developed a cramp in legs and tried to sit up and slid out of bed and 5/21/2018 - resident slipped out of bed onto the floor. R3's clinical record had no documented post fall assessments for 5/18/2018 or 5/21/2018.. This information was verified by V3 on 5/30/2018 at 10:00AM. The facility Fall Policy dated 2011 documents a post fall evaluation of the patient is to be completed timely following a fall. Upon completion of the evaluation, the physician is notified and new orders are documented, noted, and implemented. R1's facility face sheet dated 5/29/2018 documents a diagnosis of Right Hip Joint Prosthesis, Dysphasia, Hypertension, Iron	S9999			

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S9999	Continued From page 7 deficiency Anemia. The Minimum Data Set dated 3/23/2018 documents R1 is cognitively intact. On 5/29/2018 at 10:00AM R1 stated "I had a pain level of ten plus (scale of one to ten) in my right thigh, after I fell during the transfer. They put me in bed and put an ice pack on my right thigh. It was several hours later when they gave me a pain pill and the next day before I was sent to the hospital. The pain remained a ten plus even after the pain medication." On 5/29/2018 at 11:30AM, R6 (R1's roommate) stated "I heard (R1) fall. (R1) hit the floor hard. (R1) was crying and in a lot of pain after the fall. I don't know why they did not sent (R1) to the hospital right away. (R1) was crying and whimpering in pain the rest of the night." R1's progress notes dated 5/7/2018 at 11:17 PM documents at 9:15PM, R1 slid out of the sit to stand and hit the floor buttocks first. R1 complained of pain in the right inner thigh area and later the outer thigh area also. R1's progress note dated 5/8/2018 at 1:26 AM documents a portable x-ray was ordered. At 1:34AM, R1 had Tylenol 650 milligrams every six hours for pain as needed ordered and administered. The 9:17AM, progress note documents "patients right leg turned inward, complaining of severe pain. (R1) did not want anyone to turn or change (R1). Received orders to send to the local emergency room for evaluation and treatment. Family notified of transfer." R1's Medication Administration Record dated May	S9999			

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S9999	Continued From page 8 2018 documents R1 received the following pain medications after the fall at 9:15PM; Tylenol 650 milligrams at 1:34AM 5/8/2018. R1's Physician Order dated 5/8/2018 documents portable x-ray of the right leg. On 5/30/2018 V2 (Director of Nursing) verified the x-ray was not ordered STAT (immediately), therefore the x-ray would have been done the next day. R1's hospital x-ray dated 5/8/2018 at 9:44AM documents an oblique spiral fracture of the right femur with up to a 15 millimeter displacement of the distal fracture fragment. On 5/29/2018 at 11:07AM, V6 (Nurse) stated "I was on duty the night that (R1) fell. I put an ice pack on the inner and outer right thigh and later (about two hours after the fall) I gave Tylenol for pain. (R1) was trembling and whimpering after the fall complaining of pain. I called the Nurse practitioner on call. I did not get an order to send (R1) to the hospital for evaluation. I think (R1) should have probably went out for x-rays and treatment right away. I can't send a resident to the hospital without an order. I did not notice bruising at the time of the fall. I did remove the right foot from under the lift. The foot was turned sideways and caught under the lift platform. (R1)has a high pain tolerance and doesn't complain, but I could tell (R1) was in pain because of the trembling and whimpering." On 5/30/2018 at 10:30AM, V2 (Director of Nursing) stated "We do need an order to send a resident to the hospital, but we can use nursing judgement and send a resident and then get the order. I was notified the night (R1) fell. I did ask about sending (R1) out or at least getting x-rays. The x-ray should have at least been ordered	S9999			

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S9999	Continued From page 9 STAT. (R1) was sent out to the emergency room the next day before the x-ray was done. I would have sent (R1) out to the emergency room for evaluation right away if I was the nurse on duty." On 5/30/2018 at 12:05PM, V5 (Certified Nurse Aide) stated "The night (R1) fell (R1) was crying and yelling in pain. (R1) appeared in a lot of pain the rest of the shift. I work until 11:00PM. (R1) fell about 9:15PM." On 5/29/2018 at 9:50AM, V3 (Orthopedic Physician) stated "A displaced spiral fracture is very painful. Tylenol would more than likely not control the pain." (B)	S9999			