

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6015879	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 08/01/2018
NAME OF PROVIDER OR SUPPLIER MANOR COURT OF CLINTON			STREET ADDRESS, CITY, STATE, ZIP CODE 1 PARK LANE WEST CLINTON, IL 61727		
(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 Facility Report Investigation to Incident of 6/30/18 / IL 104535	S 000			
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a) 300.1210b)5) 300.1210c) 300.1210d)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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as	S9999			

Attachment A
Statement of Licensure Violations

Illinois Department of Public Health

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

TITLE

(X6) DATE

08/21/18

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S9999	Continued From page 1 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 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour,	S9999			

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S9999	Continued From page 2 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. Findings include: These Regulations were not met as evidence by: Based on observation, interview and record review, the facility failed to ensure for the Safe Resident Handling of one resident(R1). This failure resulted in R1 being sent to the emergency room with a deep laceration into the muscle of the right leg with contused tissue requiring 18 staples to close the laceration. The facility also failed to implement a plan to prevent injury for residents (R1, R2) and follow care plan to prevent injury for a resident (R3). These failures affect three of three(R1, R2, R3) residents reviewed for incidents with injury in the sample of three. The facility's Safe Resident Handling Policy dated	S9999			

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S9999	Continued From page 3 November 2012 documents that the facility will protect staff and residents from injury and limit the use of manual lifting as much as possible. The policy documents that all residents will be assessed for safe handling and moving, including the resident's ability to participate in transfers, the resident's cognition and behaviors, and the safety of the residents and staff. The policy documents that transfers without mechanical lifts are limited to residents who are able to ambulate or are stable with bearing weight. The lifting strategy may change according to the resident's condition and the instructions are care planned. This policy also documents that a non-mechanical standing device or a mechanical lift may be used instead of a manual lift at the discretion of the certified nurse's aide. 1. The facility incident report dated 6/30/18 documents R1 sustained a laceration requiring treatment (sutures) at the emergency room. The report documents R1 with diagnosis including: anxiety disorder, osteoarthritis, use of an anticoagulant, lymphedema and obesity. The report documents R1 has a BIMS of 4, Brief Interview for Mental Status score of 4 of 15 indicating cognitive impairment, and R1 is hard of hearing. R1's Care Plans dated 1/25/16 document R1's Safe Resident Handling Procedures including transfer with wheeled walker, gait belt and assist of one to two staff with cues to stand tall. These care plans also document staff may use full mechanical lift to transfer R1. There was no documentation to prevent further injury to R1 from the 6/30/18 incident. R1's Minimum Data Sets dated 4/10/18 and 7/3/18 document R1 requires extensive	S9999			

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S9999	Continued From page 4 assistance of two staff members for transfers. R1's Therapy Daily Treatment Notes documents as follows: 6/20/18- nursing reported to therapy that R1 was not well 6/19/18 and required greater assistance with transfers. 6/21/18- R1 "incredibly tired today" 6/25/18- R1 "continues to be more tired than usual, sometimes requiring more assistance than usual" 6/26/18- nursing reported to therapy R1 "is especially tired today and requiring greater assistance than usual; requiring and doing fair with stand aid versus stand pivot transfer." 6/28/18- R1 "incredibly sleepy today and difficult to rouse." R1 is requiring increased physical assistance for transfers. R1's Resident Progress Notes dated 6/30/18 documents R1 had a large pool of blood under R1's feet and R1's right pant leg was saturated with blood. This note documents R1 had a "large deep tear to the outer calf of the right leg" and that R1 was sent to the emergency room. R1's Emergency Room Report dated 6/30/18 signed by V14, Emergency Room Physician documents R1 presented with a "mechanical injury to the right lower extremity lateral aspect." This report documents while R1 was being transferred, R1 got R1's "right leg caught on the metal of the wheelchair" and the right lateral leg has a "L shaped" laceration measuring 5cm (centimeter) by 5cm into the "deep tissue." This report also documents "Wound's Depth, Shape: into muscle, linear, irregular, contused tissue", wound length 10 cm (centimeters) and that the laceration was closed with 18 staples.	S9999			

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S9999	Continued From page 5 The hospital Patient Summary dated 7/4/18 documents on 6/30/18 staff stated patient's leg became caught between the bed and wheelchair while transferring (R1). On 7/31/18 at 11:20am, V6, Certified Nursing Assistant (CNA) stated on 6/30/18, V4, CNA and V6 transferred R1 to the wheelchair. V6 stated R1's wheelchair was next to R1's bed and V4 and V6 used a gait belt and assisted R1 to a standing position. V6 stated when R1 "is ready to sit, {R1} just sits" and R1 lets R1's legs give out and stops bearing weight. V6 stated R1 does this frequently. V6 stated R1's body was "a little to the right" when R1 stopped bearing weight and "plopped" down before R1 was positioned correctly in front of the wheelchair. V6 stated R1 "bounced off" of the wheelchair and hit R1's right side. V6 stated V6 noticed R1's right leg was not positioned properly and that R1's right leg had gotten caught on the hinge of the wheelchair. On 7/31/18 at 11:05am, V5, Licensed Practical Nurse (LPN) stated a CNA of which V5 was unsure of the name of the CNA, had notified V5 there was "quite a bit of blood" on the floor. V5 stated V5 thought staff had used a non-mechanical standing aid on 6/30/18 to transfer R1. V5 stated from what V5 could see, it looked like R1's leg had gotten caught on the wheelchair during the transfer. V5 stated R1's laceration was "pretty deep." On 7/31/18 at 3:55pm, V3, Assistant Director of Nursing (ADON) stated V3 re-enacted R1's incident that had occurred on 6/30/18 with V4 and V6, CNA's. V3 stated from moment to moment, R1 can change R1's response to interactions. V3 stated that neither V4 or V6 notified V3 of R1's frequent legs giving out or	S9999		

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S9999	Continued From page 6 "plopping" in the chair. V3 stated on 6/11/18, V3 had requested therapy to evaluate R1's transfer due to R1's body being bent over during transfers. V3 stated V3 expects staff to use the amount of assistance necessary to complete a safe transfer. V3 stated if the resident can't bear weight or participate in the transfer, the staff should utilize a full mechanical lift to transfer that resident. V3 stated staff had told V3 that R1 was getting weaker and that is when V3 told staff to use a full mechanical lift for R1 if needed. V3 stated staff should use safest mode of transfer for each resident. 2. R2's Event Report dated 6/11/18 documents R2's diagnoses including Muscle Wasting and Atrophy, Muscle Weakness, Lack of Coordination and abnormalities of gait and mobility. This report documents R2's backside of the right calf had a laceration measuring 7.5cm (centimeters) in length. This report documents this was due to a self-inflicted "rub" on R2's walker. There is no documentation of interventions implemented to prevent potential reoccurrences of skin alterations from R2's walker. On 7/31/18 at 3:55pm, V3, Assistant Director of Nursing (ADON) stated R2 had gotten up independently and went to the bathroom. V3 stated V13, Certified Nursing Assistant (CNA) thought R2 had scratched R2's leg on R2's walker. V3 stated R2 "jerks" R2's walker around. When asked what intervention was implemented to prevent additional potential skin alterations in relation to R2's walker, V3 stated R2's incident with the skin alteration on 6/11/18 was "an isolated incident." 3. R3's Care Plan dated 7/30/2018 documents R3 has diagnoses of Cerebrovascular Disease,	S9999		

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S9999	Continued From page 7 Contracture of Left Hand, and Muscle Weakness. R3's Care Plan documents an approach dated 1/29/2016 to transfer R3 with a non-mechanical standing device, gait belt, and assistance of one staff member. These care plans also include R3 may use full mechanical lift. R3's care plan documents an approach dated 7/12/2018 for R3 to wear protective sleeves to both arms during transfers. R3's Event Report documents on 6/23/2018 R3 received a skin tear to right arm due to the arm of the wheelchair. This report also documents an undated evaluation note documenting that R3 has protective sleeves to wear during transfers. On 6/27/2018 at 10:39 AM, R3's Progress Notes document that R3 was requiring the assistance of two staff members for transfers. This note documents to use a full mechanical lift when R3 is unable to bear weight to stand. R3's Event Report documents on 6/29/2018 R3 received a skin tear to left arm during a transfer with the non-mechanical standing device. Occupational Therapy Notes for R3 dated 7/6/2018 documents that R3 was unable to use left arm to aid self during transfer with the non-mechanical standing device, even with the assistance from unidentified staff. R3's Progress Note dated 7/11/2018 at 4:48 PM documents R3 continues to have weakness in the right hand causing R3 to bump the arm on the non-mechanical standing device during transfers. On 7/31/2018 at 2:20 PM, V11 Certified Occupational Therapy Assistant (COTA) and V12	S9999			

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S9999	Continued From page 8 Certified Nursing Assistant (CNA) attempted to transfer R3 from the wheelchair with a non-mechanical standing device. V11 and V12 applied a gait belt and assisted R3 to a standing position and had to physically hold R3 up with the gait belt due to R3 not bearing own weight to stand up straight. R3 reached with the right hand to grab the cross bar located on the non-mechanical standing device. R3's left hand was contracted and R3 was unable to extend R3's left arm to hold onto the cross bar. R3 was unable to stand upright to allow V11 and V12 to lower the seat pads. R3 had to sit back into the wheelchair and was unable to be transferred after two attempts. R3 was not wearing protective sleeves during the transfer attempts. On 7/31/2018 at 2:35 PM, V9 CNA stated that R3 has limited mobility to left hand and arm, and if not careful R3 has a tendency to bump that arm. V9 also stated that following the skin tear on 6/29/2018 protective sleeves were used for a while and R3 is to wear them for transfers during the night. On 7/31/2018 at 3:55 PM V3, Assistant Director of Nursing (ADON) stated that R3 had been having difficulty with transfers. V3 stated V3 teaches the staff to use the safest means of transfer for each resident. The non-mechanical standing device manufacturer's manual dated with the year of 2007, documents that residents who are qualified to use the device should have adequate arm strength to pull themselves upright and enough leg strength to support themselves upright. (B)	S9999			

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