| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| S 000 | Initial Comments<br><br>Complaint Investigation:<br><br>2172621/IL132901 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations<br><br>300.610a)<br>300.1210b)5)<br>300.1210d)6)<br>300.3240a)<br><br>Section 300.610 Resident Care Policies<br><br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological | S9999 | Attachment A<br>Statement of Licensure Violations | |

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| S9999 | Continued From page 1<br>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:<br><br>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.<br><br>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:<br><br>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.<br><br>Section 300.3240 Abuse and Neglect<br><br>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)<br><br>These regulations are not met as evidenced by:<br><br>Based on interview and record review the facility | S9999 | | |

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| S9999 | Continued From page 2<br>failed to ensure that a gait belt was used during a resident's transfer and while assisting the resident to stand, to promote resident safety.<br><br>This applies to 1 of 3 residents (R1) reviewed for incident of fall with injury.<br><br>This failure resulted in R1 sustaining a fall while being assisted by a staff which resulted in hospitalization due to proximal left femoral fracture.<br><br>Findings include:<br><br>R1 has multiple diagnoses which included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, atrial fibrillation, generalized muscle weakness, primary osteoporosis of the right wrist, pain in right knee, abnormalities of gait and mobility, long term use of anticoagulant, based on R1's medical diagnosis list.<br><br>R1's quarterly MDS (minimum data set) dated 2/16/21 shows that the resident is cognitively intact and would require extensive assistance from the staff with most of her ADL (activities of daily living) including transfers, ambulation, toilet use, personal hygiene and dressing.<br><br>R1's care plan revised on 2/23/21 with a goal date of 5/17/21 shows that the resident is at risk for falls due to unsteady gait and balance, weakness and diagnosis of hemiplegia.<br><br>R1's initial incident reported to the State Agency on 4/17/21 shows that on 4/16/21 at approximately 2:00 PM, "During transfer from toilet in own room, (R1) was unable to continue to stand and bear weight and reported her leg gave | S9999 | | |

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out and needed to sit down right away landing on floor of bathroom. Initial nurse assessment no injury noted. Mild knee pain 2/10 ( 2 out of 10 on a scale of 0 to 10, with 0 being no pain and 10 being severe pain) per (R1) was same as usual and not new. Subsequent assessment still with usual mild knee discomfort but noted slight redness and swelling to left knee area. MD (Medical Director) order for portable x-ray left hip, knee. Result of x-ray left hip proximal femur fracture with degenerative changes. MD order for transfer to ER."

R1's final incident reported to the State Agency on 4/23/21 shows that on 4/16/21 at approximately 2:00 PM, "CNA (Certified Nursing Assistant) reported to nurse that during transfer from toilet in own room, (R1) was unable to continue to stand and bear weight and reported her leg gave out. Resident needed to sit down and CNA lowered resident to the floor. RN (Registered Nurse) observed the resident to be sitting on the bathroom floor with back against the wall by the door. Head to toes assessment was completed. After assessment was completed. When RN asked resident what happened, the resident stated, "My leg gave out and I needed to sit down right away." Resident was asked by RN if she had any pain. Resident stated, 'just my legs." Resident reported pain to be mild & 2/10 at her baseline when RN questioned. CNA stated that she was in the bathroom with resident that time when resident's leg gave out. According to CNA as resident was standing up without gait belt, resident stated, " I can't do this anymore." CNA tried to reach for the wheelchair but was unable to. CNA tried to place resident back to toilet but was also unable to. CNA braced resident and assisted her to the ground. CNA observed resident sitting on her left leg while on

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the ground. CNA positioned the resident to be more comfortable. Then proceeded to call Nurse on duty. Resident was placed in the bed and ensure resident was comfortable. Resident requested for pain medication. Tylenol was administered. RN checked on resident 5-10 minutes after incident to check for any pain and discomfort. Resident complaint of mild pain and requested to put pillow (between) legs and did not expressed any concerns. MD (Medical Doctor) notified and ordered X-RAY stat with results of proximal left femur fracture. MD ordered to send resident to ER."

R1's x-ray results dated 4/16/21 shows under the interpretation of the left hip, "Impacted subcapital fracture of proximal left femur" with the impression of "Proximal left femoral fracture." The same x-ray results shows under the interpretation of the left femur, "Impacted left femoral fracture" with the impression of, "Proximal left femoral fracture."

On 4/23/21 at 2:10 PM, V3 (CNA/Certified Nursing Assistant) stated that on 4/16/21 at approximately 2:00 PM she assisted R1 to the bathroom. V3 wheeled R1's wheelchair inside the bathroom and positioned the resident's wheelchair close to the toilet for R1 to reach the grab bar on the wall. R1 stood up using the grab bar. According to V3, while R1 was holding on to the grab bar, she moved the resident's wheelchair away from the resident and place it outside of the bathroom door. V3 then pulled down R1's pants and disposable brief and assisted the resident to sit on the toilet. V3 stated that while R1 was sitting on the toilet, she cleaned the resident's left thigh area because there was some fecal matter. After R1 finished using the toilet, R1 stood up by holding on to the grab bar

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(located on the right side of the toilet). According to V3, while R1 was standing and holding on to the grab bar she started cleaning R1 using the disposable wipes, then she put on a clean disposable brief for the resident. V3 stated that she secured the left side of R1's disposable brief first, then proceeded to fasten the right side and it was during that moment when R1 told her, "I can't do this anymore" which according to V3 meant that R1 cannot stand up anymore. V3 stated that it was after that statement from R1 that she noticed the resident losing her grip from the grab bar and her knees were bent as she was going down in a backward motion. According to V3, because she was positioned closer to R1's right side, she held R1's right arm with her right hand and placed her left leg on R1's back area to sit the resident down. V3 stated that when R1 was on her buttocks on the floor she noticed that R1's right leg was in a straight position parallel to the floor, while R1 was sitting on her left leg. According to V3, R1's position looked uncomfortable so, she assisted R1 in repositioning her left leg by straightening the resident's left leg parallel to the floor. V3 stated that R1 did not complain of pain. After repositioning R1, she (V3) went out of R1's room to call the nurse. V3 stated that V4 (nurse) came in and saw R1 on the bathroom floor. R1 kept on saying, "I need help" and that she wanted to go back to bed. According to V3, V4, another CNA and herself transferred R1 to bed using a full body mechanical lift. V3 stated that during the application of the lift sling and during the transfer process, R1 did not complain of pain. V3 stated that around 2:20 PM, after R1 was transferred in bed, she left the resident's room because V4 was in the room with R1. V3 stated that at around 2:50 PM, she went back to checked on R1 and according to the resident, she was "alright."

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During the same interview V3 was asked if she is the regular CNA for R1. V3 responded that she is a floater and that she has taken care of R1 prior to 4/16/21. V3 was asked how she would know what type of assistance R1 need during transfer, ambulation, and toilet use. V3 responded that she would normally ask the nurse but with regards to R1 she did not ask because R1 has a card posted on her wall that gives instructions with regards to R1's care. According to V3 the posted card indicated that R1 needed one-person assistance during transfer, ambulation, and toilet use, but it did not indicate what device to use during the transfer/assistance. V3 was asked if she used a gait belt on 4/16/21 to transfer R1, when she assisted R1 on and off the toilet, and when R1 was standing and holding on to the grab bar during perineal care. V3 responded, "no" because "she (R1) does not necessarily need the gait belt." According to V3, on 4/16/21 she had a gait belt inside her pocket when she transferred and toileted R1, however she did not use it to assist R1 because she did not feel that the resident needed it. V3 further stated that she had received training with regards to gait belt usage and was told during the training to use the gait belt as needed, when the staff feel that the resident is not strong enough or when the resident had history of fall. V3 was asked if she noticed any weakness on R1's body prior to assisting R1 to the toilet. V3 responded that R1 has weakness in her leg but she was not certain which leg it was.

On 4/23/21 at 3:29 PM, V5 (Physical Therapist) stated that based on the discharge physical therapy notes, R1 received physical therapy services at the facility from 2/3/21 through 2/23/21. V5 stated that when R1 was discharged from physical therapy on 2/23/21, it was

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documented on the therapy notes that the resident has chronic right knee pain and would require assistance from the staff during transfers due to unsteadiness. According to V5, the discharge therapy notes documented that R1 can stand with support between 1 to 3 minutes, but her standing tolerance can decrease due to pain in the right knee, therefore R1 needed assistance from the staff during transfers, ambulation and during sit to stand with the use of the gait belt. V5 stated that in general, all nursing staff (CNAs and nurses) and therapist must use a gait belt on any resident during manual transfers, ambulation and during sit to stand with 1 or 2 staff assistance, to ensure the safety of the resident. According to V5, the gait belt is used to protect the resident. V5 further stated that proper use of the gait belt provides safety in case the resident feels weak, the staff would be able to hold on the gait belt to prevent any risk of fall and could lessen the impact of injury to a resident.

The facility's gait belt/transfer belt policy and procedure dated 9/2020 shows under policy, "To assist with a transfer or ambulation. A gait belt will be used with weight bearing residents who require hands on assistance."

On 4/24/21 at 5:54 PM, V7 (Physician) was informed that based on R1's records, the resident was sent to the hospital on 4/16/21 for further evaluation and treatment because the result of R1's x-ray showed that the resident's left hip had an impacted subcapital fracture of proximal left femur and the resident's left femur had an impacted left femoral fracture. V7 stated that based on the x-ray result R1 did not have a spontaneous fracture but instead had a low or high-level impact that caused the impacted fracture. According to V7 the only reason he

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| S9999 | Continued From page 8<br>could think that caused the impacted fracture was from a fall. V7 was asked if the staff should have used a gait belt when R1 was being assisted during standing and during transfer on 4/16/21. V7 responded, "If the physical therapist says the resident needs a gait belt, it should be followed, because they are the profession with regards to that."<br><br>"B" | S9999 | | |