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
	IL6009591	A. BUILDING: ______ B. WING ______	C 06/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION CASA SCALABRINI	480 NORTH WOLF ROAD NORTHLAKE, IL 60164

(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 Complaint Investigation 2173502/IL134105	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1210a) 300.1210b)5) 300.1210c) 300.1210d)6) 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**	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S9999	Continued From page 1 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, 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)	S9999		

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These regulations were not met as evidenced by:

Based on interview and record review, the facility failed to provide the safe transfer of a resident using a sit-to-stand mechanical lift.

This resulted in R1 sustaining a left wrist (distal radial) fracture.

This applies to 1 of 3 residents (R1) reviewed for transfer with a mechanical lift in the sample of 3.

Findings include:

R1's EMR (Electronic Medical Record) shows R1 was admitted to the facility on June 14, 2018. R1 has multiple diagnoses including history of stroke, atrial fibrillation, heart failure, hypertension, renal insufficiency, diabetes mellitus type 2, arthritis, osteoporosis, and depression.

R1's fall assessment dated March 13, 2021 shows R1 was assessed to be at high risk for falls.

R1's MDS (Minimum Data Set) dated March 18, 2021 shows R1 was cognitively intact. R1 requires extensive assistance of two staff members for bed mobility, transfers, and toileting. R1's care plan dated September 2, 2020 shows an updated intervention "assist [R1] with transfers using sit-to-stand with two persons."

On May 27, 2021 at 10:27 AM, R1 was sitting in her wheelchair with a splint to her left wrist. R1 stated "my fingers and hand are swollen, the other day (V14) CNA (Certified Nurse Assistant) tried to get me out of bed to go to the bathroom by herself. She didn't have me hooked up quite right to the machine because when she started to

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move me, the belt slipped off and I fell onto the floor, hitting my head on the corner of a cabinet that is across from the foot of my bed. I had pain on the left side of my head, my left arm, left wrist, and my left hip. They tried to use a sheet to get me off the floor and that made me hurt more. They went and got the (mechanical) lift and used it to get me back to bed."

On May 27, 2021 at 10:38 AM, V10 (RN, Registered Nurse) stated "I was working when [R1] fell. It was around 11:30 AM. [V14] (CNA) was transferring [R1] to the bathroom with the sit to stand mechanical lift by herself. All the staff have been trained to use two staff at all times when using the sit to stand or any mechanical lift with a resident. [V14] told us she was trying to get [R1] up and [R1's] left hand slipped. [R1] was laying on the floor with her feet by the bed and her head was by the bathroom door. [R1] has a two drawer cabinet in her room and her head was close to that. [R1] seemed ok, the Nurse Supervisor and I both assessed [R1]. [R1] stated she couldn't hold on. [R1] was alert and oriented and kept saying she was fine and wanted to get back to bed. Four of us used the mechanical lift to get [R1] back to bed."

Facility provided V14's (CNA) statements for R1's fall on May 18, 2021. V14's statement showed, "went to take resident [R1] to bathroom in her room. She had to go immediately [I] hook [hooked] her with the [illegible] lift pad around her waist. I didn't strap the belt of the pad around her waist, the pad unstrapped came a loose and she went down to the floor. I put the pillow under her head. And I immediately called for help, and ask her if she was ok or in any pain."

V14's May 24, 2021 Incident Witness Statement

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Form included a clarification of V14's handwritten statement which showed V14 "didn't push the pad loop on the [mechanical lift] hook and the pad came undone at that site during [R1's] transfer which caused the resident to fall." The clarification continued V14 "says she aware that a second person should have been with her during the transfer."

R1's hospital records from her emergency room visit dated May 20, 2020 shows R1 fell two days earlier and complained of left sided hip pain and head pain, and her physical exam showed R1 had a left occipital scalp hematoma and Left distal radial fracture.

On May 27, 2021 at 2:10 PM, V13 (NP, Nurse Practitioner) stated R1's fracture was the result of the staff member trying to transfer R1 by herself and dropping her since there was no other way that she could have fractured her wrist.

On May 27, 2021 at 9:40 AM, V7 (CNA) stated we use two staff members whenever we use one of the mechanical lifts to transfer a resident. One staff is responsible for watching the resident and the other staff member will control the lift and move the machine to get the resident where we need to, from the bed to chair, chair to toilet, etc. V8 (CNA) also added we have to use two staff when using the lift equipment for safety.

On May 27, 2021 at 10:35 AM, V9 (CNA) stated when using the mechanical lift machines, we must use two staff members. In order to use the sit to stand mechanical lift for transfers, the resident must be able to hold onto the handles at all times as the machine helps them stand. If they cannot do that, then we use the other full-body mechanical lift.

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On May 27, 2021 at 11:34 AM, V12 (RN) stated all residents have a care card inside their closet door with information on how the resident transfers, either one or two-person, or if they require the use of a mechanical lift. All residents that require the mechanical lift automatically are a two-person transfer.

On May 27, 2021 at 11:57 AM, V11 (RN) stated any resident requiring transfer with a mechanical lift always needs to be transferred by two staff, no exceptions. Staff can check the care card in the resident's closet if they are not sure how the resident transfers.

On May 30, 2021 at 12:12 PM, V2 (Director of Nursing) described her expectations of the staff when transferring a resident using a sit-to-stand mechanical lift. V2 stated that the shortest pad loops need to be attached to the hooks, and then the safety belt should be secured (at the waist) with the buckle. V2 continued that at this time is when the staff need to call for another staff to come assist with the transfer. One staff will assist in maneuvering and operating the machine while the other staff will be on the side to monitor and support the resident's movement. They should double check that all the loops are secured to the hooks before raising the resident.

Facility policy titled Safe Lifting and Moving of Patients dated December 2019 shows the purpose is to protect the safety and well-being of associates and residents. Policy Interpretation and Implementation shows "... (G) Associates will be observed for competency in using the mechanical lifts and observed periodically for adherence to policies and procedures regarding... safe lifting techniques."

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Prior to the survey date, the facility took the following actions to correct the noncompliance:

1.) On May 18, 2021, R1's care plan was reviewed and updated to address R1's current condition.

2.) On May 25, 2021, a community review was completed by the IDT (Interdisciplinary Team) to identify like residents that are at risk to be affected by the identified unsafe practice. No other residents were identified as being affected by the failed practice.

3.) On May 20, and May 24, 2021, the clinical staff were re-educated on the facility process for the safe transfer of residents with a sit-to-stand or a full mechanical lift, requiring two staff members, and the importance of following the step-by-step procedures on the sit-to-stand and mechanical lifts. Employees will be required to complete a return demonstration to validate competency by May 25, 2021. Facility provided completed competencies. Inservice was done for all staff except the 11 staff on leave. The staff on leave at this time will be required to complete in-service and return demonstration before they return to work. V8 and V9 (CNAs) were interviewed regarding the training and return demonstration.

4.) On May 26, 2021 at 6:30 PM, the facility's QA (Quality Assurance) audit tool was used to monitor a resident being transferred by two staff using the sit to stand mechanical lift.

"B"