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
	IL6004675	A. BUILDING: ______ B. WING ______	C 08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCOLADE PAXTON SENIOR LIVING	450 FULTON STREET PAXTON, IL 60957

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S 000	Initial Comments	S 000		
	Investigation of Facility Reported Incident of 7/22/22/IL149601			
S9999	Final Observations	S9999		
	Statement of Licensure Violations:			
	300.610a) 300.1210b)5) 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		**Attachment A** Statement of Licensure Violations	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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:

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.

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 observation, interview and record review the facility failed to complete a transfer for a resident according to the resident's plan of care for one resident (R2) reviewed for accidents. This failure resulted in R2 sustaining a Right Humerus Fracture (an injury to the bone of the upper arm

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S9999	Continued From page 2 that connects the shoulder to the elbow), and R2 was admitted to the hospital. Findings include: The facility's Transfers policy with a revised date of 1/2020 documents, "Purpose: To provide guidelines to nursing assistant/nurse for proper technique for transferring residents. Policy: To promote safe transfer for the residents, as well as the staff, gait belts, (mechanical lift), and/or sit to stand will be used, unless otherwise specified. Responsibility: It is the responsibility of all nursing staff to ensure the use of safe transfer techniques when transferring a resident. It is the responsibility of the D.O.N. (Director of Nursing)/Designee to ensure that adequate training is provided to all nursing staff on the proper use of gait belts, (mechanical lifts) and sit to stand." "Procedure:" "3. A minimum of two staff members is recommended when transferring with a (mechanical lift). 4. When using a (mechanical lift) pay close attention to be sure that the (mechanical lift) sling is properly positioned." "7. Follow Plan of Care to ensure the use of proper transfer technique." The facility's Resident Handling Policy dated 8/2017 documents, "Purpose: To provide guidance to staff in the proper handling/lifting of residents." "It is the responsibility of the CNAs (Certified Nursing Assistants)/Restorative Aide to transfer/ambulate according to assessed needs." R2's Order Summary Report dated 8/2/22 documents diagnoses including Spondylolisthesis, Lumbosacral Region, Unspecified Osteoarthritis, Presence of Left Artificial Knee Joint, Other Malaise, Other Specified Disorders of Bone Density,	S9999		

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S9999	Continued From page 3 Unsteadiness on Feet, Contracture Left Knee, Contracture Right Knee, Cognitive Communication Deficit, Hereditary and Idiopathic Neuropathy, Other Lack of Coordination, Contracture Left Hip and Contracture Right Hip. This Order Summary documents an order for Fentanyl patch 72-hour 25 mcg (microgram)/hr (hour), apply one patch transdermally every 72 hours for pain management and remove per schedule with a start date of 7/30/22. This Order Summary also documents an order for Morphine Sulfate (Concentrate) Solution 20 mg (milligrams)/ml (milliliter), give 0.25 ml by mouth every four hours as needed for pain or air hunger with a start date of 7/28/22. Also, Norco tablet 5-325 mg, give one tablet by mouth every six hours as needed for breakthrough pain with a start date of 7/28/22. R2's Care Plan dated 2/26/21 documents R2 was at risk for falls related to Confusion, Deconditioning, (Mechanical Lift) transfers, staff assist with ADL's (Activities of Daily Living). R2's Care Plan dated 2/26/21 documents R2 has an ADL self-care performance deficit related to Activity Intolerance, BLE (Bilateral Lower Extremities) Contracture's, Presence of Left Artificial Knee Joint, Pain, Secondary to diagnosis HF (Heart Failure), Iron Deficiency Anemia, Depression, Right and Left Hip Contractures, Neuropathy and Osteoarthritis. Interventions documented for this problem are for transfers, R2 requires Full Mechanical Lift x (times) 2 staff assistance for transfers dated 3/13/2020. R2's Minimum Data Set (MDS) dated 5/5/22 documents R2 has severely impaired cognition and is totally dependent on two or more staff for transfers and for bathing.	S9999		

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S9999	Continued From page 4 R2's Kardex Report dated 8/2/22 provided by V3 Director of Nursing documents R2 requires a mechanical lift with two staff assistance for transfers. On 8/2/22 at 4:30 PM, V10 Care Plan Coordinator confirmed the CNAs (Certified Nursing Assistants) get the resident's information from the Kardex. V10 stated it is the Care Plan for the residents. R2's Original Incident Report documents, "On 7/22/22 at 1:55 PM (V1) Administrator was notified that (R2) was complaining of shoulder pain during (R2's) shower. (R2's) right shoulder appeared swollen. (R2) was laid down in bed and a full body assessment was completed. All 3 C.N.A.'s that assisted in (R2's) shower were suspended pending investigation. (V12) Nurse Practitioner notified and ordered stat (immediate) X-rays to right shoulder, POA (Power of Attorney), and (hospice company) also notified. Initial report emailed to (reporting agency). X-ray results showed a Right Humerus Fx. (fracture). Doctor, POA, and Hospice notified; (R2) was then sent to (the hospital) for tx (treatment)." On 8/2/22 at 7:30 AM, V5 Registered Nurse stated regarding R2 that all three CNAs got fired (employment terminated) because they were supposed to use a mechanical lift for transfers for R2 but did not. On 8/2/22 at 11:49 AM, V4 Licensed Practical Nurse (LPN)/Nurse Manager stated on 7/22/22 V4 was working in V4's office and the floor nurse, V6 LPN came into V4's office and asked V4 to look at R2's shoulder in the shower room. V4 stated R2's shoulder appeared swollen and V4 stated V4 instructed the CNAs to lay R2 down in bed. V4 stated V4 contacted V12 Nurse Practitioner and x-rays were ordered. V4 stated	S9999		

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S9999	Continued From page 5	S9999		

V7 and V8 CNAs stated R2 started complaining of pain during the shower. V4 stated V9 CNA told V4 that V9 lifted R2 up out of the geriatric reclining chair while V7 and V8 removed R2's clothing and then V9 sat R2 on the shower chair. V4 stated all three CNAs were terminated for not following R2's plan of care for transfers. V4 stated R2 was supposed to be transferred using a mechanical lift.

On 8/2/22 at 1:07 PM, V1 Administrator stated on 7/22/22 V1 was not in the building and was notified by V4 regarding R2's pain and swelling and improper transfer in the shower room by V7, V8 and V9. V1 stated V7, V8 and V9 were all suspended immediately pending an investigation. V1 stated V7 and V8 told V1 that they were going to give R2 a shower but the mechanical lift sling that was underneath R2 did not have a cut out on the bottom to be able to wash R2's perineal area. V7 and V8 requested help from V9. V1 stated V9 went into the shower room and lifted R2 up off the geriatric reclining chair while V7 and V8 removed R2's clothing and then V9 sat R2 down on the shower chair. V1 stated R2 should have been transferred using a mechanical lift. V1 stated V7, V8 and V9 were all terminated on 7/28/22 for not following R2's plan of care.

On 8/2/22 at 1:35 PM, V3 Director of Nursing stated V3 was notified regarding R2's incident by V4. V3 stated V4 explained what had happened. V3 stated the CNAs are supposed to get resident care information from the Kardex. V3 stated they just completed an inservice with the staff regarding how to find all of the resident's information. V3 confirmed R2 was only supposed to be transferred using a mechanical lift. V3 stated R2 was and still is in a lot of pain. They had R2 on a five day course of Norco and now

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S9999	Continued From page 6 have transitioned to a Fentanyl patch to help manage the pain. V3 stated R2 used to be able to feed R2's self but now R2 cannot due to the fracture. On 8/2/22 at 2:57 PM, V7 stated V7 and V8 were going to give R2 a shower but the mechanical lift sling that was underneath R2 did not have a cut out to clean the perineal area. V7 stated that they got V9 to assist. V7 stated V9 told V7 that V9 has done this before. V7 stated V9 wrapped V9's arms underneath R2's arm pits and gave R2 a bear hug and picked R2 up like that from the geriatric reclining chair. V7 stated R2 started yelling when V9 picked R2 up. V7 stated that during R2's shower R2 was moaning and started to look pale and greyish in color. V7 stated they went to get the nurse at that point. On 8/2/22 at 3:06 PM, V8 stated that V8 was the shower aide that day and R2 was on the list for a shower. V8 stated that V8 asked V7 to assist with the shower. V8 stated the mechanical lift sling underneath R2 did not have the cut out on the bottom to be able to wash R2's perineal area. V8 stated that V8 and V7 did not feel comfortable transferring R2 by themselves so they got help. V9 came to help transfer R2. V8 stated that V9 lifted R2 up from the geriatric reclining chair and V7 and V8 removed R2's clothing and then V9 sat R2 down on the shower chair. V8 stated that during the shower when V8 lifted R2's arms up R2 started screaming. V8 stated they went to get the nurse. V8 stated that V8 knew R2 was a mechanical lift transfer but other staff had told V8 that they have transferred R2 with 2 people before instead of a mechanical lift so V8 stated V8 thought it was ok to do so. On 8/2/22 at 3:15 PM, V6 LPN stated one of the	S9999		

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S9999	Continued From page 7	S9999		

CNAs came to get V6 and took V6 to the shower room. V6 stated that when V6 touched R2's right shoulder R2 moaned and flinched. V6 stated that V6 went to get V4 Nurse Manager. V6 stated that V4 took over from there. V6 stated that V6 did not witness the transfer or anything else.

On 8/3/22 at 7:27 AM, V11 R1's Physician stated V11 was aware of R2's Humerus fracture and the improper transfer. V11 confirmed the improper transfer could have caused the fracture of R2's right Humerus.

On 8/3/22 at 7:44 AM, R2 stated R2 does not remember how R2's arm got broke. R2 stated that R2 still has a lot of pain and is tired. R2 was laying in bed with a pillow underneath the right arm and right arm was in a sling.

Hospital documentation dated 7/22/22 documents expected stay at least two days.

Hospital Radiology report dated 7/22/22 documents Findings of R2's x-ray as "Oblique fracture of the proximal humerus abdomen just below the surgical neck, with medial apex angulation and impaction. Impression: Oblique impacted fracture of the proximal humerus."

V7, V8 and V9's Notice of Termination of Employment form documents V7, V8 and V9 were all terminated on 7/28/22 with the reason of "failure to follow patient's plan of care resulting in injury." All three termination notices are signed by V1 and V3.

(A)