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	IL6012595	A. BUILDING: _____ B. WING _____	C 08/14/2022

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ELEVATE CARE ABINGTON	3901 GLENVIEW ROAD GLENVIEW, IL 60025

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S 000	Initial Comments Facility Reported Incident of 7/3/22/ IL149489	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210 b) 300.1210d)6) 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 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: 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 These requirments are not met as evidenced by: Based on interview and record review, the facility failed to ensure that a resident was provided with	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 safe care in a manner, considering the resident's history of refusal of care and aggressive behavior toward staff; the resident became aggressive with staff while incontinence care was being provided and the staff member was not familiar with the resident or related interventions for care; the resident then had a fall, and staff proceeded to transfer the resident from the floor to the bed, using a mechanical lift, while the resident continued to be in an agitated state. This failure applied to one (R5) of three residents reviewed for accidents and supervision; and, resulted in R5 having a diagnosis of right femur fracture. Findings include: R5 is a 74-year-old female originally admitted to the facility on 4/18/20. R5 has medical diagnoses that include unspecified fracture of lower end of right femur, morbid (severe) obesity, vascular dementia with behavioral disturbance, muscle weakness, repeated falls, and history of falling. R5's current MDS (Minimum Data Set) Assessment dated June 3, 2022, documents: Section C (Cognitive Patterns) No - attempt to conduct interview with resident (resident is rarely/never understood) Section G (Functional Status) Bed Mobility - 3. Extensive assistance / 2. One-person physical assist Transfer - 7. Activity occurred only once or twice / 3. Two+ persons physical assist Bathing - 4. Total dependence / 2. One-person physical assist Functional Limitation in Range of Motion - 2. Impairment on both sides / 2. Lower extremity (hip, knee, ankle, foot)	S9999		

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S9999	Continued From page 2 Facility provided initial incident report form which documents the following: Reportable Event Occurred on: Date: 7/3/22 Time: 4:45am Reported by: V2 Director of Nursing "On 7/3/22 the resident was eased to the floor during a behavioral incident while receiving incontinence care. Upon easing the resident to the floor, the resident's combativeness increased, and she began to kick her legs and swing her arms around. Additional staff were called to the room for support. The resident was immediately assessed by nursing staff. Vitals were attempted but the resident refused. A whole body assessment was also attempted but also refused by the resident despite multiple attempts for education. Limited assessment was able to be done as allowed by the resident. The resident verbalized that she had pain in her right knee upon palpation and movements by the resident. Telehealth evaluation was performed by (V14 Medical Doctor). X-rays were ordered by the physician but refused multiple times by the resident. The resident also refused further examination or interventions by staff. Immobilization of the site was attempted as best as possible with use of pillows and frequent reminders and education on importance of use and compliance was given to the resident. Multiple attempts to provide PRN pain medication were given. She finally agreed to take PRN Tylenol at 10:20 am. Her pain continued to be monitored and PRN medication continued to be offered and administered as needed. She has a long-standing history of refusal of care and lack of cooperation with staff. The nurse practitioner and family were made aware of all matters. Family was asked to come to facility to in education and cooperation of resident for x-ray or	S9999		

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S9999	Continued From page 3	S9999		

further intervention. The resident agreed to have the x-ray taken after multiple attempts from family present in facility. X-ray results returned with results of "valgus deformity is noted. Distal femoral acute fracture with impaction. Marked degenerative changes. Osteopenia. After discussion with NP, family, and resident a current do-not-hospitalize order was revoked and an order to send to (local hospital) for evaluation was given. The resident's sister will be present in the facility to aid in compliance with the transfer. Staff will follow up with (local hospital) ER for residents' status. The physician and family were made aware of all matters. Investigation was initiated."

8/14/22 at 1:45pm V17 (CNA) stated, I had just started working at the facility on July 1st and this was my first-time taking care of (R5). I was providing incontinence care. No one ever told me that she was so aggressive. Not until after she fell, then they told me that she is always aggressive with everyone and that when she acts that way, you can't change her, you just have to leave her like that. But that's not right either, to leave her sitting there dirty. She was being very aggressive since I walked in the room. Saying nasty things to me and being extremely rude. She is very aggressive. When she was starting to fall, I went to her side and assisted her down because I can't lift her. I laid her on the floor and put a pillow under her and called the nurse. She was yelling and screaming at everyone the entire time. I don't really know their names because I never worked on that floor again after that night. I just remember one CNA and there were two other nurses, I think. I know that I called for the nurse right away though. When R5 was on the floor, she was kicking and hit the dresser (next to the bed) and scratched her right toe (I believe). She wasn't complaining of pain or anything, the only

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S9999	Continued From page 4	S9999		

thing we noticed was the skin tear on her toe from kicking the dresser. She made no complaints of pain while she was on the floor. The nurse assessed her first and then we had to use the mechanical lift to get her off the floor. I told them (other staff in the room), let's use the mechanical lift and they said, how are we going to use the lift? I told them that I have a lot of experience and we can use the lift. When asked how they used the lift with the resident on the floor kicking and screaming, with four people in such a tight space, V17 stated, well, we moved the bed and then used the mechanical lift. While we were using the lift, she was still yelling and being aggressive, the whole time she was being aggressive; she did not calm down until she got on the bed. The other CNA and I managed to get the sling under her and then we used the lift to move her. The nurse was trying to get her to calm down and explain to her that we had to get her on the bed, but she was screaming obscenities and saying that she was going to get us fired. Once she was in the bed, we settled her in, and the nurse checked her again. I think they sent her to the hospital afterwards, I don't know; I haven't worked with her since. V17 then affirmed that none of the nurses or other staff who were familiar with R5 gave her any education or instructions on how to care for R5 even though she has a history of refusing care and being aggressive towards staff; V17 stated that she had no prior knowledge of the type of care/interventions R5 required prior to walking into her room that night.

8/13/22 at 12:42pm, V13 (LPN) stated, I was in the nurse station charting and I heard the CNA yell for help, and I went immediately to investigate. R5 was on the floor and kind of combative, kicking and swinging her arms. I tried to calm her down and re-direct her behavior, but

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S9999	Continued From page 5	S9999		

she was already very mad and upset. I observed her on the floor beside her bed and I assessed her. I tried to take her vitals, but she refused. I only remember that she was complaining of pain on the right knee. I offered her a pain pill, but she refused. She was alert x2 at this time and her level of consciousness did not change so I called for help to use the mechanical lift to transfer her back to bed. When she was on the bed, I talked to her and tried to calm her down. I offered her pain medication again and she still refused. I told her I would be back and to press the call light if she needs something. I called the doctor, and he ordered an x-ray, and I called her power of attorney. The pain was new, and she pointed to her right knee. I ordered the x-ray STAT. I think it was done in the morning. It was probably around 4am when the fall occurred. There was nothing unusual about her knee, no swelling or bruising. (R5) was just complaining of the pain and I could see that she could bend it. When she was in the bed, I looked again, and her knee did not look swollen or asymmetrical. I did not suspect any injury or fracture.

8/12/22 at 11:45pm, when asked about R5's fall on 7/3/22, V16 (CNA) stated, yes, I was working but I wasn't assigned to her. I think it was a new CNA (V17 CNA). The nurse called me to help; (R5) was already on the floor. I don't remember exactly who all was there, but it was four of us. We used the mechanical lift and put her back on the bed. V16 accompanied surveyor into the room that R5 was residing in at the time of the fall and demonstrated for surveyor how the resident was found when he entered the room. The bed was near the window/wall/AC side of the room and in between the bed and A/C unit, there was a dresser at the head of the bed approximately two feet wide. Per V16, R5 was on the floor, in

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S9999	Continued From page 6	S9999		

between the bed and the AC unit, (directionally) her head was at the foot of the bed and her feet were toward the top of the bed, so she was able to kick the dresser that was next to the bed. Surveyor asked how four people and a mechanical lift were able to safely transfer the resident, who is obese, in such a tight space. V16 replied that they moved the bed over and then transferred the resident.

8/13/22 at 4:32pm, V18 (RN) confirmed being the oncoming nurse after R5's fall. Per V18, after multiple refusals, R5's family came to the facility and convinced the resident to get the x-ray and eventually go to the hospital. V18 affirmed being very familiar with R5 and stated, (R5) doesn't like me so she always refuses medication or that I provide any care for her. If she likes you, she will get along better, but mostly she just refuses everything. V18 stated that since the fracture was confirmed with the x-ray in the facility, R5 was given narcotic pain medication in preparation for transfer to the hospital since it was expected that she would have pain with movement/transferring. When asked about transferring a resident after a fall, V18 stated, before you move the patient you have to assess range of motion and ask if they hit their head and assess for any obvious injuries. If there is acute pain, then I would call the physician and ask for an x-ray. If a patient has a fall and then complains of pain with movement, I would not transfer them (using mechanical lift). I would call the physician and then 911 to send them to the hospital.

Nursing Progress Note dated 7/3/22 06:24 written by V13 (LPN) reads:
Writer was told by the CNA that resident was on the floor assisted by CNA. Writer went to the

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S9999	Continued From page 7 resident's room and noticed resident lying flat and both legs extended on the floor. Resident was alert and responsive, oriented x2. No changed in level of consciousness. Assessment done on both upper and lower extremities. Complained of pain on right knee when touched and during movements. Writer called on call Dr. and asked for Xray on right knee and Neuro check. Writer texted (named facility management) and made aware of the incident as well." Telehealth Evaluation (written by V14 Medical Doctor) Effective Date 7/3/2022 4:53AM "Primary Chief Complaint: Fall with injury ...C/O right knee pain ...Review of systems (includes) MS/extremities: Pos for injury, R knee pain ...MSK: lim range of motion, R knee tenderness ...Diagnosis, Assessment/Plan (TE): A: R knee pain P: R knee xray - Pain in right knee (Primary) Orders: R knee xray Neuro checks Notify THE of any change in condition. Disposition: Stay at Facility." Nursing Progress Note dated 7/3/2022 13:55, written by V12 (LPN) reads: "Received resident in bed sleeping in bed in no apparent distress. Upon medication pass at 8:30AM resident complained of pain in her right knee. She was unable to quantify her pain or provide further description. She was noted guarding her lower extremity. No other indicators of pain. Writer attempted to check her vitals, but the resident refused. No range of motion was attempted. The resident was instructed not to move her extremity any further and her leg was immobilized with the use of pillow. The resident was offered PRN Tylenol but refused it." Nursing Progress Note dated 7/3/2022 23:07,	S9999		

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S9999	Continued From page 8 written by V15 (RN) reads: "At 10:00pm, called (x-ray company) to f/u x-ray of right knee results, impression: valgus deformity is noted. Distal femoral acute fracture with impaction. Marked degenerative changes. Osteopenia. Informed POA about the x-ray results, both in agreement to send resident to the hospital for evaluation. Called ambulance (company) at 10:30pm ...ETA in 1-2 hours. PRN Norco given at 10:00 pm for pain. Right leg immobilized with pillow. (Relative) returned to the facility at 11:00pm, she will accompany resident to the hospital." Review of R5's medical record includes multiple progress notes and documentation of resident long history of refusing care and aggressive behaviors towards staff with no indication of improvement or change in behavior. R5 current care plans include the following focus areas: Behavior Symptoms "(R5) displays aggressive and agitated behavioral symptoms. These behavioral symptoms are manifested by resisting direct care and refusing any physicians to assess her. (R5) refuses assistance for basic care such as taking showers, taking medications, basic hygiene, and meals. Staff continue to educate and redirect her on the importance of complying with care. However, she continues to be non-compliant. (R5) will be verbally aggressive and hostile towards staff when care is being rendered or when staff visit her to address her needs." Date Initiated: 10/02/2020 Revision on: 07/25/2022 Interventions include (but not limited to): "If resident resists with ADLs, reassure resident,	S9999		

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S9999	Continued From page 9 leave and return 5-10 minutes later and try again ...Provide resident with opportunities for choice during care provision." Date Initiated: 10/02/2020 Revision on: 10/02/2020 "(R5) will often times become upset and/or agitated with staff. Staff reports that she can be verbally aggressive daily when care is being rendered. She is noted to yell, scream and/or curse at staff. Often, it can be difficult to redirect her. When staff will ask her questions, she will often tell staff to leave her alone. Psych consult is being recommended for mood and behavioral management. Resident has a hx to refuse psychiatry consults, medications, and treatments. Staff to continue to offer support, redirect, and educate as needed." Date Initiated: 09/01/2021 Revision on: 09/01/2021 Interventions include (but not limited to): "Analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document." Date Initiated: 09/01/2021 Created on: 09/01/2021 Behaviors - Refusal "(R5) will refuse to be weighed, take medications, and follow treatment orders. When staff attempt to redirect and educate on the importance of adhering to care recommendations and orders, she will yell, scream and/or curse at staff. It can be difficult to redirect resident. Staff are to continue to redirect, offer support, and educate." Date Initiated: 06/07/2022 Created on: 06/07/2022 Interventions include (but not limited to): "Anticipate and meet the resident's needs."	S9999		

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S9999	Continued From page 10 Date Initiated: 06/07/2022 Created on: 06/07/2022 "(R5) has potential impairment to skin integrity r/t history of healed sacral stage 3 pressure wound and healed deep tissue injury right posterior achilles due to fall at home and suffered an avulsion fracture to her right calcaneus, COPD, C. Diff and OSA." Date Initiated: 07/08/2022 Created on: 03/26/2022 Revision on: 07/08/2022 Interventions include (but not limited to): "Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface." Date Initiated: 03/09/2022 Created on: 03/26/2022 During the course of this survey, reviewed current care plan documents for R5 (36 pages) and there was no inclusion of interventions for how to safely transfer the resident (i.e., from bed to wheelchair, etc.). 8/13/22 at 5:30pm, V2 (Director of Nursing) stated, (R5) hit her leg with the side of the table when she fell because she was kicking and screaming with a behavior. (After the fall) R5 was transferred with the mechanical lift and then was complaining of pain in her knee. She went to the hospital after many refusals with her sister. We were able to do the x-ray and then the sister was able to convince her to go to the hospital. If the patient fell on the floor, we send them to the hospital if we suspect major injury or fracture, if so, we don't move them, we immobilize ...if we are able to safely transfer back to the bed we do. If there is pain with movement, I would not	S9999		

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S9999	Continued From page 11 assume that is related to a fracture - but it would be an indication for an x-ray if it's new pain. When she was in bed she started complaining of the pain in her knee; she did not complain of pain until she was in the bed. The nurse had to clear the commotion around her first and then they transferred her back, but she didn't start complaining of pain until she was on the bed. Surveyor asked V2 if it seemed safe to transfer the resident using a mechanical lift if the resident was agitated and/or complaining of pain. V2 responded, I would still do the transfer with a mechanical lift if it was leg or arm pain. When she was kicking the dresser, it was with her upper shin. I don't think they transferred her while she was agitated ...It would probably be safer not to touch her. If I was the nurse on the floor, it would be better to call 911 ...I don't think she has a history of falls. V2 confirmed that this information was based on staff reports provided, as he did not personally witness the events related to R5's fall. Facility document titled, Fall Prevention Program (Effective Date: 11/28/12 and Revisions: 11/21/27) reads: "Purpose: To assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. Quality Assurance Programs will monitor the program to assure ongoing effectiveness ...Nursing personnel will be informed of residents who are at risk of falling. The fall risk interventions will be identified on the care plan ...This policy is a guideline only. Each resident has his or her own set of circumstances which may require that this policy not be followed.	S9999		

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S9999	Continued From page 12 The needs of each resident supersede this policy." (B)	S9999		