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
	IL6009302	A. BUILDING: ______ B. WING ______	C 03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOME	418 WASHINGTON STREET QUINCY, IL 62301

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S 000	Initial Comments Complaint Investigation 2322326/IL157783	S 000		
S9999	Final Observations Statment of Licensure Violations: 300.610a) 300.690b) 300.690c) 300.1210b) 300.1210d)6) 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 300.690 Incidents and Accidents b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. 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	S9999		

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that each resident receives adequate supervision and assistance to prevent accidents.

These requirements are not met as evidenced by:

Based on interview and record review the facility failed to ensure a resident was properly transferred; and the facility failed to report a fall with serious injury to the State Agency which affected one of three residents (R1) reviewed for accidents/incidents in a sample of three. This failure resulted in R1 being lowered to the floor during an improper transfer causing significant bruising, a hematoma, and requiring hospitalization in the Intensive Care Unit for a contusion of unspecified front wall of thorax and a large left anterior chest wall hematoma.

Findings include:

R1's list of current diagnoses includes Dementia, Psychotic Disturbance, Anxiety, Morbid (Severe) Obesity, and General Muscle Weakness.

R1's Minimum Data Set (MDS) assessment dated 1/11/23 documents that R1 is totally dependent on two staff for transfers, does not walk, and uses a wheelchair for mobility. In addition, this MDS documents that when R1 goes from a sit to stand position, meaning R1's ability to come to a standing position from sitting in a chair, wheelchair, or the side of the bed, R1 is dependent on staff to do all the effort where R1 does none of the activity or requires two or more staff to assist R1 to complete the activity.

R1's care plan dated 1/19/23 documents that R1 requires the use of a full mechanical lift (A device to transfer a resident who is laying down) with two people for transferring but may use a sit stand

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mechanical lift, where R1 must hold on to handles, stand, and maintain body weight on his legs during the transfer, for toileting. In addition, R1's care plan documents R1 is at high risk for falls because of incontinence, and gait and balance problems. This same fall care plan documents for staff to use the full mechanical lift due to R1's inability to stand for long. R1's fall prevention focus dated 3/15/23 documents that R1 was lowered to the floor on that date and that the intervention of "staff reeducated on appropriate lift use for resident's level of care" was added.

R1's Investigation Report Form with interviews dated 3/21/23 documents that on 3/15/23 at 5:30a.m. V4 (Certified Nurse Aide/CNA) and V5 (CNA) entered R1's room to get R1 up for the day. V4 and V5 noted that R1's full mechanical lift sling was wet, so they obtained a sit/stand mechanical lift and sling then proceeded to stand R1. While pulling up R1's pants, R1's knees began to buckle at which time V4 and V5 lowered R1 to the floor with no injuries noted at that time. This investigation documents that during the night of 3/15/23, R1 began complaining of pain to R1's left upper arm and a large bruise was found upon R1's assessment. On 3/18/23 R1 was sent emergently to the hospital because R1's bruising had increased in size and because R1 was experiencing increased pain. In V4's written statement, V4 explained that V4 and another CNA were attempting to get R1 up for the day but were unable to find a full mechanical lift sling to transfer R1. V4 stated that she and the other CNA used a sit/stand mechanical lift, where the sling fits around R1's chest and lifts R1 into a standing position, to stand R1 up to transfer. V4 stated that while the CNAs were pulling up R1's pants, R1's legs gave out and R1 was lowered by the CNAs

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S9999	Continued From page 4 to the floor. In V5's written statement, V5 explained that V5 and another CNA were getting R1 up for the day. V5 stated that R1's full mechanical lift sling was soiled from urine from the previous night and the CNAs could not find another sling to use for R1. V5 stated that she and the other CNA decided to use the sit/stand mechanical lift to stand R1 because R1 was on their list of residents who needed to get up during their shift. V5 explained, " The (other) aide and I decided to use the (sit/stand) lift. At times, day shift and other night shift aides have used the (sit/stand) lift on (R1) due to no clean slings in (R1's) room or even on the unit." V5 continued to explain that once V4 and V5 stood R1, R1 became weak, and his knees began to buckle so V4 and V5 lowered R1 to the floor. In addition, R1's fall investigation documents that V4 and V5 were interviewed by V6 (Human Resources) who documented that, "Both of them was put (through) transfer training and received a final warning." In addition, this fall investigation does not include documentation that R1's fall with injury was reported to the State Agency as required. On 3/27/23 at 1:24p.m. V5 verified that R1 was lowered to the floor on 3/15/23 when V4 and V5 used the sit/stand standing mechanical lift to transfer R1 instead of the full mechanical lift. V5 stated that she and V4 used a regular sit/stand sling around R1 but that R1 is a very large resident who should have a larger sling to fit him. V5 stated that during R1's transfer on 3/15/23, she and V4 placed the sit/stand sling around R1's chest below his breast area so it would stay in place. V4 stated that when R1's knees began to buckle, the sit/stand sling began to slide up as R1's arms went up in the air and that's when V4 and V5 lowered R1 to the floor.	S9999		

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R1's progress note dated 3/15/23 at 5:30a.m., late entry, documents that R1's legs became weak during a mechanical lift transfer and was lowered to the floor. R1's progress note dated 3/16/23 at 2:03a.m. documents that R1 complained of pain to his left upper arm at which time a large dark blue bruise was noted. Upon further inspection, the nurse noted R1's bruise was becoming firm to the touch. R1's progress note dated 2/16/23 at 9:27a.m. documents R1's left chest bruise was hard to the touch and that R1 was anxious and yelling out for staff, which this note states, "is unusual for (R1) during the day." This same note documents that R1 complained that he "Hurt all over," and was administered as needed Acetaminophen for pain which was not effective. R1's progress note dated 3/18/23 at 3:26a.m. documents R1's bruising to his front left chest had spread around to R1's left back at which time R1 was sent to the ER for treatment. R1's progress note dated 3/18/23 at 1:33p.m. documents that R1 was admitted to the Intensive Care Unit of the hospital for close monitoring for active bleeding.

R1's hospital emergency room (ER) physician's note dated 3/18/23 states, "Started having spontaneous bruising. Eliquis discontinued couple of days ago. May have fallen out of (mechanical) lift recently. Comes in today with significant soft tissue (Hematoma/pooling of blood under the skin due to injury). Large chest wall bruise on the left side. Left leg is swollen." This same note documents under assessment and plan that the hospital physicians would be addressing concerns including soft tissue hematoma, traumatic from fall, and Anemia from acute blood loss. On 3/19/23 R1's Complete Blood Count laboratory (Lab) findings document

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