STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009096	A. BUILDING: _____ B. WING _____	C 06/18/2023

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S 000	Initial Comments Complaint Survey: 2393346/IL159023, 2393444/IL159097 & FRI of 1/24/2023/IL157453	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2 1. 300.610a) 300.1210b) 300.1210d)3 300.1210d)5 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 300.1210 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. These Requirements were not met as evidenced by: Based on interview and record review the facility failed to prevent a facility acquired pressure ulcer from developing, failed to develop and implement a care plan with pressure relieving interventions to prevent a pressure ulcer from developing, failed to develop and implement a care plan with	S9999		

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interventions to address a pressure ulcer once developed, and failed to do skin checks for one of three residents (R4) reviewed for pressure ulcers in the sample of five. These failures resulted in R4, who was admitted to the facility without pressure ulcers, developing a stage two pressure ulcer to the right heel that progressed to an unstageable infected pressure ulcer that required R4 to be hospitalized and treated with intravenous antibiotics.

Findings include:

The facility's Wound Care Program policy dated 7-1-22 documents, "It is the policy of this facility to ensure that residents whose clinical conditions and medical diagnosis potentiate the risk for skin breakdown and development of pressure ulcers are properly identified, assessed, and managed according to current regulatory guidelines and standard of care. Procedures: 1. Timely identification of residents assessed to be at risk for skin breakdown. Each risk factor and potential causes identified with the Braden scale (wound risk assessment) should be reviewed individually and addressed into the resident's care plan. Facility shall develop a plan of care and implement interventions according to the resident's Braden score and/or identified individual risk factors. Prevention of skin breakdown: Inspection of the skin every shift with care for signs of breakdown. Activity, Mobility, and Positioning: Establish an individualized turning and repositioning schedule of the resident if immobile or with impaired physical functioning. The resident's care plan shall be evaluated and revised based on resident's response to treatment, treatment goals and outcomes. Pressure Ulcer Treatment: Initiate wound care treatment upon identification of the wound with

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S9999	Continued From page 3 physician's order. Develop a care plan with appropriate interventions." R4's Admission Record documents R4 was admitted to the facility on 8-19-22 with the diagnoses of Spinal Stenosis, Need for Assistance with Personal Care, Weakness, Lack of Coordination, and Mild Intellectual Disabilities. R4's Progress Notes dated 9-28-22 document R4 was discharged to the hospital on 9-28-22 and did not return to the facility. R4's MDS (Minimum Data Set) Assessment dated 8-26-22 documents R4 was a 73-year-old admitted to the facility on 8-19-22. This same MDS documents R4 was moderately cognitively impaired, required extensive assistance of one staff for bed mobility, transfers, dressing, and toileting. R4's Admission Skin Evaluation dated 8-19-22 documents R4 was admitted with normal, warm skin and had no pressure ulcers upon admission. This same evaluation documents R4 had a non-pressure skin condition to the right great toe, is assessed to be at risk for pressure sore development related to fragile skin, incontinence, and impaired mobility, and should have heels offloaded with pillow while in bed. R4's Wound Risk Assessment dated 8-20-22 and 8-27-22 documents R4 is at risk for developing pressure ulcers. R4's Wound Summary and Wound Assessment Details Report dated 8-25-22 through 9-27-22 documents R4 developed a partial thickness pressure ulcer to the right heel on 8-25-22 that measured 5.0 cm (centimeters) by 3.0 cm by an	S9999		

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S9999	Continued From page 4 unknown depth and had a scant amount of sero-sanguineous (clear pinkish) exudate (drainage). R4's Progress Notes dated 8-26-22 and signed by V31 (LPN/Licensed Practical Nurse) documents, "Writer spoke to (V32/R4's Power of Attorney) to give them an update on resident's skin integrity and wound care consultant visit from 8-25-22. Writer also addressed right heel blister that was noted on 8-25-22. (V32) was made aware. Writer will continue to monitor resident." R4's Care Plan dated 8-19-22 through 9-8-22 (hospital admission) does not include a plan of care to address R4's pressure ulcer to the right heel identified on 8-25-22. This same Care Plan does not include pressure relieving interventions to prevent the development of a pressure ulcers before the development of R4's pressure ulcer to the right heel on 8-25-22. R4's Electronic Health Record does not include documentation of skin checks being performed every shift by the nurses or CNAs (Certified Nursing Assistants) as directed by the facility policy and does not include documentation of daily or weekly skin checks being performed by the nurses. R4's Physician's Order Sheet and Treatment Administration Records dated 8-19-22 (Admission) through 8-31-22 document R4 did not receive an order, or a treatment for the right heel until 8-27-22 (two days after discovery). R4's Physician's Order dated 8-27-22 documents, "Right heel: Cleanse with normal saline, pat dry, apply bacitracin plus xeroform and cover with border gauze every day shift every Tuesday, Thursday, and Saturday."	S9999		

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R4's Arterial Duplex Scan Radiology Results Report of the lower bilateral extremities dated 9-2-22 documents "Clinical Information: Right lower extremity wound to the right heel. Impressions: No evidence of hemodynamically significant luminal stenosis (narrowing of the blood vessels) in visualized vessels."

R4's Hospital History and Physical dated 9-9-22 and signed by V30 (R4's Hospital Physician) documents, "(R4) is sent to the emergency room because of wound on the right foot with infection there. Leukocytosis (high white blood count) admitted with antibiotics for right lower extremity wound infection and wound care on consult. Admitted for further evaluation and treatment. (R4) given IV (Intravenous Meropenem/Antibiotic) in the emergency department. Assessment and Plan: Unstageable pressure ulcer right heel. Recommend betadine dressing changes twice a day per nursing. In addition to foam offloading boots, would keep pillows under his calf to float the heel."

On 6-16-23 at 12:15 PM V32 (R4's Power of Attorney) stated, "(The facility) did nothing to prevent (R4's) pressure ulcer to the heel. Every time I would go to the facility, staff would not re-position (R4) or do anything for (R4). That is why I had (R4) move to a different facility and had (R4) sent to the hospital. When (R4) went to the facility he did not have any pressure ulcers."

On 6-16-23 at 5:35 PM V14 (Nurse Consultant) stated, "(R4's) pressure ulcer to the right heel was facility acquired."

On 6-16-23 at 6:00 PM V2 (Director of Nursing) stated that CNAs are supposed to do skin checks

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S9999	Continued From page 6 every shift and document them on the residents. V2 stated R4 does not have skin checks documented every shift and did not have a plan of care for pressure relieving interventions developed or implemented prior to R4 developing the pressure ulcer to his right heel, and R4 did not have a care plan implemented with interventions to address and treat R4's pressure ulcer once developed. (A) 2. 300.610a) 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 300.1210 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	S9999		

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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 Requirements were not met as evidenced by:

Based on interview, observation, and record review the facility failed to use an appropriate mechanical lift sling per manufacturer's instructions during a transfer and failed to transfer a resident safely, as directed by the facility's policy, using a mechanical lift for one of three residents (R3) reviewed for falls in the sample of five. These failures resulted in a mechanical lift tipping over with R3 during a transfer from the bed to the wheelchair, resulting in the mechanical lift falling on R3's left arm, fracturing the left radial head (knobby area of the radius where it meets the elbow) of R3's left arm.

Findings include:

The facility's Mechanical Lift Transfers policy dated 1-14-13 documents, "Procedures: 1.

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Follow manufacturer's guidelines on how to operate machine. 4. Use sling compatible with mechanical lift and appropriate size. 5. There will always be two staff to assist resident. One staff will control the lift as the other will guide resident and support back and neck to transfer surface. 11. Lift resident up from the chair using lift with one person operating the machine while the other staff removes the resident's wheelchair/recliner out of the way while resident is suspended in the air. For a brief second, the second staff won't be able to put hands on the sling as staff removes the wheelchair or recliner. 12. The second staff will guide resident and sling as resident is transferred and lowered back to bed. 14. When lifting resident from bed to chair, one staff will also operate the machine while one staff guides the sling."

The (Manufacturer's) User Manual for the Mechanical Lift Model dated 10-1-18 documents, "Ensure the legs of the lift with patient in the sling are in the open position. Press the legs open button until maximum open position. Do not use slings and patient lifts of different manufacturers. Slings are made specifically for use with mechancial lifts. Injury or damage may occur. Warning: When using an adjustable base lift, the legs must be in the maximum opened/locked position before lifting the resident."

R3's MDS (Minimum Data Set) Assessment dated 2-9-23 documents R3 is at 77-year-old that is cognitively intact. This same MDS also documents R3 requires extensive assistance of two plus physical assist of staff for bed mobility and requires total assistance of two plus staff for transfers.

R3's Incident Note dated 1/24/2023 at 2:42 PM

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and signed by V3 (LPN/Licensed Practical Nurse) documents, "Incident Summary: Prior to the incident 11:50 AM, resident (R3) was in bed. Around 1:50 PM two CNAs (Certified Nursing Assistants) were transferring (R3) from the bed to the wheelchair with Hoyer lift (mechanical lift). CNAs called for help and three other staff went in to assist in re-positioning (R3) upright in the wheelchair. (R3) alert and oriented times three. (R3) was asked what happened and resident stated "the (mechanical) lift was toppling over and I hit my left arm to the (mechanical lift)." Body assessment done. No apparent injuries noted. No swelling noted to the arm. Resident complained of mild pain to the left arm. Tylenol 650 mg (milligrams) given. No other complaints. V17 (Nurse Practitioner) was notified with an order for x-ray to left arm/hand."

R3's Left Elbow X-Ray report dated 1-25-23 documents, "Impression: Small left elbow effusion, Cortical step-off of radial head, concerning for non-displaced left radial head fracture."

V21 and V20's (Agency CNAs) Statement Forms dated 1-24-23 document around 12:15 PM on 1-24-23 both V20 and V21 were transferring R3 from the bed to the wheelchair using the (mechanical lift). During the transfer the mechanical lift toppled over and V20 and V21 supported R3 to the wheelchair. R3 landed in the wheelchair leaning toward the left.

On 6-16-23 at 9:45 AM R3 was lying in a bariatric bed. R3 was holding his left arm. R3 stated, "On (1-24-23) two agency staff were transferring me from my wheelchair to the bed. The two staff did not know what they were doing and were moving the Hoyer (mechanical lift) to fast and was jerking

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the lift. The lift tipped over with me in it and I fell hard into my wheelchair. The (mechanical lift) fell on top of me, hitting my left arm and my head. The lift broke my left arm. It hurt for a little while. The staff tipped the lift over on me sometime last year also. The lift tipped forward while I was in the wheelchair and pinned me against the wall, scratching my face."

On 6-16-23 at 10:30 AM V15 (CNA/Certified Nursing Assistant) and V16 (CNA) transferred R3 from the bed to the wheelchair using a bariatric mechanical lift and sling labeled with another manufacturer name. During the transfer V16 raised R3 off of the bed with the mechanical lift and transferred, R3 with the mechanical lift from the bed to the wheelchair that was located 10 feet from the bed. R3 was suspended in the air, without staff support behind his back, head, or neck during the transport from the bed to wheelchair. V15 was standing beside R3's wheelchair during the transfer from the bed to wheelchair.

On 6-16-23 at 12:48 PM V3 (LPN) stated, "The (mechanical lift) was toppling over and fell on (R3), hitting (R3) on the shoulder. Two CNAs were transferring (R3). I assessed (R3) and he had some pain in his left shoulder. We got an order for an x-ray, and they found (R3's) arm was fractured."

On 6-16-23 at 12:56 PM V23 (Building Maintenance Director) stated, "I have always ordered 'Drive' brand mechanical lift slings for the mechanical lifts. I thought 'Drive' slings were compatible to use with the lifts."

On 6-16-23 at 1:55 PM V21 (Agency CNA) stated, "On (1-24-23) me and V20 (Agency CNA)

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S9999	Continued From page 11 were transferring (R3) from the bed to the wheelchair. During the transfer, the (mechanical lift) started to tip over, and the back wheel came off of the floor. We had to hold (R3) up and get him into the wheelchair. (R3) had hit his arm on the (mechanical lift) when the (mechanical lift) started to topple over. I am not sure why the (mechanical lift) tipped." On 6-16-23 at 4:00 PM V24 (Mechanical Lift Manufacturer's Representative) stated, "(The Manufacturer) cannot guarantee the safety of residents during a transfer with our (mechanical lift) model unless the facility uses our manufacturer's slings. Any other manufacturer's slings are not guaranteed to be safe." On 6-16-23 at 4:05 PM V2 (Director of Nursing) stated, "Two staff should do a mechanical lift transfer. While the resident is suspended in the air and being transferred to the wheelchair from the bed, so one will control the lift and the other staff will support the resident behind the resident's head and neck until they get the resident close to the wheelchair. One staff will then lower the resident with the lift, while the other maneuvers the resident into the wheelchair. I know (R3) got fracture to the left arm from the (mechanical lift) tipping over on him." (B)	S9999		