

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6009799</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/22/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PAVILION OF WAUKEGAN</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2217 WASHINGTON STREET WAUKEGAN, IL 60085</b>
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S 000	Initial Comments  Complaint Survey #23110459/L167829	S 000		
S9999	Final Observations  Statement of Licensure Violations  300.610a) 300.1210a) 300.1210b) 300.1210c) 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  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	S9999	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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S9999	<p>Continued From page 1</p> <p>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)</p> <p>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.</p> <p>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</p> <p>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:</p> <p>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.</p> <p>These Requirements were not met evidenced by:</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>Based on observation, interview, and record review the facility failed to safely transfer a resident (R1). This failure resulted in R1 being hit in the head with the arm of the mechanical lift, resulting in a large skin tear, being admitted to the hospital, and requiring sutures to her head. This applies to one of three residents (R1) reviewed for safety in the sample of five.</p> <p>The findings include:</p> <p>The facility assessment dated 12/2/23 shows R1 to be cognitively intact, requires maximum assistance for her activities of daily living and uses a mechanical lift for her transfers.</p> <p>On 12/21/23 at 11:15 AM, R1 said she was being lifted from her bed to her wheelchair using the mechanical lift. R1 said as she was being lowered to her wheelchair, the arm bar on the lift hit her in the head. R1 said she saw stars and was in a lot of pain. R1 said she had to be taken to the hospital for sutures, and had to spend the night and have scans to her brain to rule out a brain injury. R1 said she was very scared and in a lot of pain after the incident.</p> <p>On 12/21/23 at 12:15 PM, V8 Certified Nursing Assistant (CNA) said she was one of the two CNA's transferring R1 when she hit her head. V8 said she was directing the lift and the other CNA (V10) was guiding R1 into her chair. V8 said after R1 was in the chair she moved forward and hit her head on the bar.</p> <p>On 12/21/23 at 12:40 PM, V10 said he was assisting with the transfer of R1 into her wheelchair. V10 said R1 hit her head on the lift bar and it began to bleed. V10 said it happened</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>so fast, but he did not remember where he was during the transfer.</p> <p>On 12/21/23 at 2:23 PM, V2 Licensed Practical Nurse (LPN) said he does the staff training for the mechanical lifts and the staff are trained to always have two staff present, one staff is to drive the lift and the other staff is responsible for guiding the resident safely to their chair or bed. V2 said the lift used for the incident was pulled from use. It was inspected and a padding was added to the arm of the lift.</p> <p>Observations of the facility mechanical lifts was completed on 12/21/23. Numerous mechanical lifts were observed in the facility. Only one lift was observed with padding to the arm of the lift and was located on the first floor. R1 resides on the second floor. A mechanical lift was observed outside R1's room, but no padding was observed to the arm of the lift.</p> <p>The facility report regarding the incident dated 11/23/23 shows R1 recieved a skin tear to her right forehead measuring approximately 10 centimeters. A pressure dressing was applied, 911 was called and R1 was sent to the local hospital.</p> <p>The emergency room report dated 11/23/23 shows R1 had a mechanical lift dropped on her head, which required nine staples and 14 sutures to her right forehead and scalp. The open area was reported to be approximately 12 centimeters in length. R1 was kept at the hospital overnight to rule out brain injury.</p> <p>The facility total mechanical lift competency checklist with a revision date of 4/2008 shows a).two caregivers are present during the transfer,</p>	S9999		

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S9999	Continued From page 4  h) gently raises the resident minimally from surface, i). turn resident legs toward the perpendicular support bar during the move and j). gently lower the resident into proper position. (B)	S9999			