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S 000	Initial Comments Compliant Investigation #2452782/IL171725	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such	S9999		

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accident, injury or change in condition at the time of notification.

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 requirements are not met as evidenced by:

Based on interview and record review, the facility failed to ensure safe resident transfers were provided to prevent accidents for 2 (R1 and R2) of 3 residents reviewed for accidents and supervision in the sample of 4. This failure resulted in R1 sustaining a laceration to the right foot requiring sutures and R2 sustaining a fibula fracture.

Findings include:

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1. R1's face sheet documented an admission date of 3/28/24, a discharge date of 4/10/24, and diagnoses including: urinary tract infection, laceration without foreign body of unspecified toe without damage to nail, metabolic encephalopathy, paraplegia, lymphedema, anemia, type 2 diabetes mellitus.

On 4/11/24 at 1:31 PM, V4 (Licensed Practical Nurse/LPN) stated she was called to R1's room on 4/8/24 to help transfer R1 onto his motorized wheelchair. V4 said while R1 was in the mechanical lift sling the wheelchair moved causing R1's foot to be lacerated by the bedframe. V4 said she applied pressure to R1's laceration to slow the bleeding and called for emergency services to transfer R1 to the hospital. V4 said R1's laceration "looked pretty deep."

On 4/12/24 at 9:57 AM, V10 (CNA) said she was assisting R1 to transfer to his motorized wheelchair on 4/8/24. V10 said that R1's motorized wheelchair was sitting parallel with the bed when R1 was transferred onto it with a mechanical lift. V10 said while staff were trying to position R1, R1 hit the controls on the motorized wheelchair causing the wheelchair to turn and R1's foot to be cut by the bedframe. V10 said once staff got R1's foot out from under the bedframe a laceration was seen with heavy bleeding. V10 said staff assisted R1 back to the bed and R1 was sent to the hospital for further treatment.

On 4/12/24 at 10:16 AM, V9 (CNA) stated that on 4/8/24 she was assisting R1 to get cleaned up for the day and get R1 in his motorized wheelchair. V9 said staff used a mechanical lift to get R1 out of bed and onto the motorized wheelchair. V9

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said as staff were attempting to move R1 back into the seat for better positioning the motorized wheelchair came on and moved causing R1's foot to be sent under the bedframe. V9 said once R1's foot was under the bedframe staff used the joystick control on the motorized wheelchair to move the chair back. V9 said this caused a laceration to R1's foot that was bleeding heavily.

On 4/12/24 at 11:28 AM, V7 (Therapy Director) said all residents who wish to use a motorized wheelchair must be assessed by therapy for safety. V7 said R1 had not been assessed for motorized wheelchair safety when the 4/8/24 incident happened. V7 said she was not made aware R1 had a motorized wheelchair until after the 4/8/24 incident. V7 said staff should ensure the motorized wheelchair is off prior to transferring someone onto it.

On 4/12/24 at 11:59 AM, V2 (Director of Nursing/ DON) said she expected staff to notify her of a family bringing in a motorized wheelchair as the resident would need to wait to use it until therapy could assess the resident for safety. V2 said she expected staff to notify her if any resident family brings Durable Medical Equipment (DME) into the facility.

On 4/12/24 at 1:05 PM, V8 (Certified Nursing Assistant/CNA) said R1's family brought R1's motorized wheelchair into the facility on 4/8/24 at approximately 10:30 AM.

R1's progress note dated 4/8/24 at 12:08 PM documented in part "...Between 11:15 and 11:20 AM, during a transfer from his bed to his chair using a hoyer lift, this resident sustained a deep laceration to his right 4th metatarsal. Towels were applied to his right foot to staunch the flow of

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blood. 911 was called for transfer to a hospital. After the bleeding slowed down to a slower continuous bleeding a pressure dressing of 4 X 4s and an abdominal pad were applied to the area. This dressing was then reinforced with tape..."

R1's progress note dated 4/8/24 at 5:35 PM documented in part "... (Nurse Practitioner) at facility and made aware of incident. Facility notified by family that resident will require sutures. (V1 Administrator) notified. Awaiting resident return..."

R1's progress note dated 4/8/24 at 6:42 PM documented in part "...(R1) returned from the (Hospital) about 5:30 pm, after having his right 4th metatarsal stitched with 7 internal and 7 external stitches. He is doing okay. The foot has a dressing that is intact, but since the doctor left a small opening for drainage, there is some blood coming out. This is expected, so blood won't build up under the skin or around the toe..."

R1's 4/8/24 hospital medical record documented in part "... right foot with starburst pattern laceration overlying the 5th MCP (metacarpophalangeal) joint. 2 cm (centimeters) in diameter with approximately 3 cm length of affected skin. Laceration affects underlying facia with approximately 0.7 cm deep puncture wound just proximal to the web between fourth and fifth toes. (R1) with complete loss of feeling in both feet at his baseline...seven 4 - 0 running Vicyl internal sutures and 7 interrupted 4 - 0 nylon external sutures..."

The facility's June 2013 Motorized Mobility Aides in the LTC (Long Term Care) Residence- Policy Considerations documented in part "...housing

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providers must also permit manually operated wheelchairs and other manually operated assistive devices without exception. Housing providers must also permit individuals who use power- driven mobility devices to utilize same, unless it can be shown by the housing provider that an individual's use fundamentally alters its programs, services, activities, or creates a direct threat, and/or safety hazard..."

2. R2's face sheet documented an admission date of 1/17/24 and diagnoses including: dementia, atherosclerotic heart disease, hypertension, anxiety disorder, contusion of right ankle.

R2's 1/23/24 Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 00, indicating R2 is severely cognitively impaired.

R2's progress note dated 3/13/2024 at 7:00 PM documented in part "... (V11, Wound Physician) in facility to round on wound to left foot at approximately (7:00 PM). Continue treatment per eTar (Electronic Treatment Administration Record). Right foot currently bruised with no swelling observed. Both (V11) and (V12 LPN) palpated foot with no observed (signs or symptoms) of pain. No complaints of pain. No new orders. (V2 DON) notified. Resident had previous fall with eye currently bruised purplish red as well ..."

R2's progress note dated 3/14/2024 at 05:34 PM documented in part "...(R2) in bed was seen by (V11) yesterday- right foot swollen, bruised and painful. Unsure of his orders. Did call (V13, Nurse Practitioner) (new order) received for a right foot and ankle x-ray. Did make POA (Power of

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S9999	Continued From page 6 Attorney) aware and x-ray set up for tonight ..." R2's 3/14/24 Patient Report of the right ankle x-ray documented in part "... an oblique fracture is noted involving the distal fibula..." R2's 3/14/24 incident investigation contained a note from V7 (Therapy Director/Family Member) and documented in part "... I have transferred (R2) multiple times... there have been several instances where she is unable to assist with the pivot portion of a transfer. I have noticed that when she cannot assist with the pivot, her feet do get caught up in the wheels of her (wheelchair). This has happened during our transfers a few times ..." R2's 3/19/24 Detailed Incident Summary by V1 (Administrator) documented in part "...Per the facility protocol an investigation was completed to identify the cause of the fractured extremity. It was found that the resident's (R2's) feet would become entangled in the wheelchair foot rests during transfers, and cause a twisting of the ankle ..." On 4/12/24 at 9:14 AM, V16 (LPN) said she was caring for R2 on 3/13/24 during the day shift. V16 said she did not see any bruising or swelling of R2's ankle during her shift. V16 said no staff reported any new injuries to R2 during her shift. On 4/12/24 at 9:39 AM, V15 (CNA) said she was caring for R2 on 3/14/24 during the dayshift. V15 said when she assisted R2 back to bed after the noontime meal she noticed bruising to R2's right ankle. V15 said when R2's ankle was moved R2 complained of pain. V15 said she reported R2's right ankle bruise and complaints of pain to V4 (LPN) immediately.	S9999		

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On 4/12/24 at 10:07 AM, V14 (CNA) said she was caring for R2 on 3/13/24 during the dayshift. V14 said she did not see any bruising to R2 right ankle. V14 said R2 did not complain of any pain to her right ankle during transfers on 3/13/24. V14 said if she had noticed any bruising to R2's ankle she would have reported it to the nurse.

On 4/12/24 at 10:43 AM, V12 (LPN) said she arrived at the facility to start her shift at 6:00 PM on 3/13/24. V12 said as she was administering medications to residents, V11 (Wound Physician) had alerted her R2 had a bruise to her right ankle. V12 said she went to assess R2 and R2's right ankle was bruised. V12 said R2's right ankle was not swollen and R2 did not complain of any pain with palpation. V12 said she notified V2 (DON) of R2's bruise and was told R2 had previously fallen, and the bruising was known about. V12 said she did not work on R2's hall often and was not aware the bruise to the right ankle was a new injury.

On 4/12/24 at 11:28 AM, V7 (Therapy Director/Family Member) said she was very familiar with R2. V7 said she had transferred R2 several times. V7 said there are times R2 will not follow queuing to move R2's feet during a transfer and R2's feet will get caught up on the wheelchair. V7 said she was not sure how R2's fibula sustained a fracture. V7 said it was possible R2's foot got caught under the wheelchair pedal and R2 moved the wheelchair causing the fracture.

On 4/12/24 at 11:59 AM, V2 (DON) said she did not recall V12 (LPN) notifying her of any new bruise to R2's ankle on 3/13/24. V2 said if she had been notified, she would have instructed V12 no notify V13 (Nurse Practitioner).

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On 4/12/24 at 1:31 PM, V4 (LPN) said on 3/14/24 staff reported to her R2 had some bruising on her right ankle. V4 said after she assessed R2 she contacted V13 (Nurse Practitioner) to obtain an order for an x-ray of R2's ankle. V4 said R2 complained of pain when the right foot was moved left and right.

On 4/15/24 at 10:42 AM, V1 (Administrator) said V7 (Therapy Director) had told him of R2's feet getting tangled in the footrests on R2's wheelchair at times. V1 said in the course of his investigation of the 3/14/24 incident, no other staff had told him of R2's feet getting tangled on the footrests of her wheelchair during transfers. V1 said it was an assumption that R2's foot got entangled in R2's wheelchair's footrests causing R2's fibula to become fractured. V1 said he was not sure exactly how R2's fibula sustained a fracture.

On 4/15/24 at 12:36 PM, V13 (Nurse Practitioner) said she would expect staff to notify her of any new bruises or injuries to residents. V13 said she was not notified of R2's right ankle bruise until 3/14/24 when she ordered an x-ray.

The facility's February 2012 Change in Condition policy documented in part " ... 1. The staff person who first notices the change reports resident change in condition immediately to the licensed nurse. 2. The licensed nurse assesses the resident ... signs, symptoms and any physical and/ or mental changes in condition. 3 ... sign, symptoms and any physical and/ or mental changes in condition are documented in the resident's medical record. 4. The resident's primary physician or designated alternate will be notified immediately of any change in a resident's physical or medical condition, this includes: b.

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	Deterioration in health, mental, or psychosocial status. C. Need to alter treatment ..."			
	(A)			