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| S 000 | Initial Comments<br><br>FRI of 4/26/2024/IL173405 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations<br><br>300.1210b)<br>300.1210d)6<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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.<br><br>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:<br><br>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.<br><br>These Requirements were NOT MET as evidenced by: | S9999 | | |

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Based on interview and record review, the facility failed to safely transfer a resident with a mechanic lift. This failure resulted in staff transferring R2 to bed from wheelchair via mechanical lift, during the transfer R2's left foot bumped the footboard which resulted in fracture to the left distal tibia. This failure affected 1 resident (R2) in a sample of 5 reviewed for accidents.

Findings include,

Facility's reportable to state agency (4/29/24) documents in part: R2 was observed by floor nurse exhibiting s/s (signs and symptoms) of pain. PRN (as needed) pain medication given and effective. MD (doctor) made aware and gave an order for x-ray. The X-ray showed a fracture to the left distal tibia. Family and MD made aware, orders received to transfer resident to the ED (emergency department) for further evaluation and treatment. Family made aware of transfer. Upon investigation it was found that on 4/26/24 V14 (CNA) stated that as she and V13 (CNA) were transferring R2 to bed from wheelchair via mechanical lift. During the transfer, R2's weight shifted causing her left foot to bump the footboard. R2 was safely positioned in bed, and V12 (LPN) was summoned to assess R2. V12-V14 all stated that R2 did not complain of pain or discomfort at this time. V12 stated that she assessed R2 and noted no visible signs of injury no bruising, redness or swelling and no skin alterations to that area. V13 and V14 went on to assist R2 with ADL (incontinence care) care in bed and R2 still did not display any signs of discomfort. R2 rested comfortably in bed for the rest of their shift. R2 was assessed for pain every shift, daily, with out change until 4/29/24. On

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4/29/24 Staff nurse noticed the area to be tender to touch. PRN pain medications given with effectiveness. Ice pack applied and leg elevated. MD made aware with order for x-ray. Family notified. X-ray results showed fracture of distal tibia. MD made aware with order to send R2 out to hospital for evaluation and treatment. Family made aware. R2 remains in the hospital at this time and plan of care will be updated upon her return.

R2 was alert and oriented with a BIMS (Brief Interview for Mental Status) of 9 (meaning moderately impaired). R2's diagnosis included but are not limited to: Altered Mental Status, History of Falling, Difficulty in Walking, Muscle Weakness.

On 6/8/24 at 9:25 am, V12 (Licensed Practical Nurse ) said she recalls the incident. V12 said, on 4/26/24 she (V12) and V14 (Certified Nursing Assistant) were assigned to R2. V12 said, V14 came and got her and said that upon transferring R2, her foot hit the foot board, she assessed the resident and there was no pain, no bruising was noted and that was it. V12 said, she does not recall writing a progress note about this incident. V12 said, with mechanical lifts there needs to be 2 people. When asked V12 should this incident be reported to V2 (Director of Nursing), V12 said no, because R2 didn't complain of pain, she was normal upon inspection, there was nothing alarming for V12 to go further. V12 said, she has been working in the facility for little over 3 years. Review of R2's progress notes affirms V12 did not document R2 hitting her leg on the foorboard on 4/26/24.

On 6/8/24 at 10:20 am V2 (Director of Nursing) said on 4/29 V17 (LPN) asked for V2 to go and

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| S9999 | Continued From page 3<br>see R2's left ankle as the resident was complaining of pain. V2 said, facility sent R2 to the hospital, at that point V2 started to ask questions to what happened and she got many witness statements. V2 said, her investigation revealed that V14 (Certified Nursing Assistant) and V13 (Certified Nursing Assistant) were transferring R2 via mechanical lift and the pad shifted, as they were lowering her down R2 hit her foot on the foot board, it has a wood foot board. R2's assigned CNA was V14 and V13 was orienting. V2 said, V13 was a cna who just started working at the facility and just needed a 3 day orientation. V2 said, both V13 and V14 could not explain how the mechanical lift pad shifted. V2 said, per their statements, V13 was guiding the lift while V14 was operating the mechanical lift. V2 said both staff said they hooked the pad on the lift, when they were lowering R2 down, the pad shifted and when she hit her foot, they got the nurse immediately. V2 said, staff could not explain how the "pad shifted" causing the injury, that it jsut happened. V2 said, regarding procedure for a resident incident it, there should be an incident report opened from that, and V2 should have been made aware of the incident. V2 said regarding operationg a mechanical lift, it should be 2 people, staff need to make sure the pad is placed correctly under the resident, and all rings are secured on the mechanical lift, than once all is secure that the resident can be transfered. V2 said, the purpose of 2 person assist with mechanical lifts is to prevent injury. V2 again said, V13 and V14 both said the mechanical lift pad shifted and they could not explain how that happened. V2 said, after this incident, all cna's got mechanical lift hand on training and V13 and V14 also got a written test on mechanical lifts. V2 said, she has been working in the facility since March 2024 and she | S9999 | | |

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does not know what kind of mechanical lift training staff received prior to the incident. V2 said, regarding V13 and V14, they no longer work here and facility has not been able to get in touch with them, they do not answer their phone. V2 said, the root cause of R2's injury was improper transfer.

On 6/8/24 at 11:30 am V2 (DON) said the facility schedule for 4/26/24 shows V16 (CNA) as assigned to R2 but it was V14 (CNA) and she was training V13.

On 6/8/24 at 12:32 V2 said, she did not fill out risk management regarding R2 and root cause was shifting of the hoyer pad, however she would not explain how that happened.

On 6/10/24 V2 provided document stating V13 (CNA) started working in the facility on 4/24/24 and her last day was 5/21/24.

Facility's "time care report" affirms V13 and V14 were on duty on 4/26/24.

V12's (LPN) statement regarding R2 dated 4/30/24 documents in part: I (V12) was the nurse on duty. I was called to the room to assess patient after being transfer to bed via mechanical lift. Per cna's pt's foot hit footboard upon transferring to bed. Noticed no signs of pain/bruising/redness. Pt was continue to monitor throughout shift.

V13's (CNA) statement regarding R2 dated 5/2/24 documents in part: V13 was training with another cna and we were putting resident to bed with a mechanical lift and she hit her foot on the bed. Cna went to get the nurse and then I helped cna finish getting resident comfortable in bed.

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| S9999 | Continued From page 5<br><br>V14's (CNA) statement regarding R2 dated 4/30/24 documents in part: I (V14) worked with R2 on 4/26. As me and another cna were putting her back to bed with a mechanical lift. The mechanical pad shifted as we were lowering her down to bed and her foot hit the foot board. Resident did not show any signs of pain. I assisted her with ADL's (activity of daily living) and made her comfortable for the night.<br><br>R2's care plan documents in part: R2 Requires use of full body lift for transfer. Diagnosis includes: impaired mobility, generalized weakness (Date Initiated: 08/27/2021, Revision on: 06/08/2024) Interventions: Full body lift with 2 person assist for all transfers (Date Initiated: 08/27/2021, Revision on: 06/08/2024). Ensure the full body lift legs are adequately spread for increased base of support (Date Initiated: 08/27/2021, Revision on: 06/08/2024), Ensure resident is in the center of the full body lift pad before beginning transfer (Date Initiated: 08/27/2021, Revision on: 06/08/2024), Staff to support Carol body and legs during full body lift transfer (Date Initiated: 08/27/2021, Revision on: 06/08/2024).<br><br>Facility policy "Transfers- Manual Gait Belt and Mechanical Lifts" (Effective Date: 11-28-12, Revisions: 1-19-18) documents in part:<br>Purpose: In order to protect the safety and well-being of the Staff and Residents, and to promote quality care, this facility will use Mechanical lifting devices for the lifting and movement of Residents.<br>Guidelines: 1. Mechanical lifting devices shall be used for any resident needing a two person assist, or who cannot be transferred comfortably and/or safely by normal transfer technique. | S9999 | | |

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| S9999 | Continued From page 6<br><br>Except during emergency situations or unavoidable circumstances, manual lifting is not permitted. 2. Staff responsible for direct resident care will be trained in the use of mechanical lifting devices annually and as needed. Refer to Manufacturer ' s Guide for proper instructions for use of equipment for transfer and weighing.<br><br>On 6/8/2024 at 11:45am V18 (LPN) stated, when there is a fall or injury we have to document in the electronic medical record and complete risk management section. We get a statement from the CNA and follow the fall protocol, we document in the medical record. There is a lot of documentation that we have to do if there is a fall. We call the doctor, the POA, and the DON.<br><br>On 6/8/2024 at 11:56am surveyor continued interview with V18 and asked V18 if a resident sustains an injury when the CNA is using a mechanical lift, what is supposed to occur. V18 stated, the CNA has to tell the nurse right away. The nurse has to come and assess right away and make sure the resident if okay and safe. I would have the resident put back in the bed or stop the transfer depending on my assessment. I would do a full body assessment, get vitals, contact the doctor, family and DON. I would have to get a statement from the CNAs that were there, follow the fall policy, and fill out the risk management information which is in the computer. There is also a fall packet with questions that have to be completed. The nurse has to be involved in assessing the resident, documenting in the nurses note, notify the doctor, and family member. The DON has to be notified for any resident that has a fall, injury or abuse. Surveyor asked V18 what is the purpose of having 2 people present when using a mechanical lift. V18 stated, to make sure the | S9999 | | |

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resident does not get injured and does not fall. One person controls the mechanical lift and the other person makes sure the resident does not sustain any injury like hit their arm, leg or head. We know how to transfer because of the colored dot on the door by the residents name.

On 6/8/2024 at 12:16pm surveyor asked V20 (CNA) if she had training on how to use mechanical lift. V20 stated, yes we have to use 2 people, put a pad underneath and lift mechanical lift. One person does the mechanical lift and the other person makes sure the resident does not move because the resident's head could get hit or legs. If the resident falls or gets injured when using the mechanical lift, I call the nurse and let them know what happened. I have to tell the nurse what happened because we are supposed to let the nurse or supervisor know what happened. The nurse will come and check the resident and does an assessment and will ask the resident of they are okay and I follow the directions of the nurse.

On 6/8/2024 at 12:51pm surveyors asked V1 about the incident that occurred on 4/26/24. V1 stated, we talked to both CNAs, but they did not tell us everything. V1 stated V13 (CNA) and V14 (CNA) received discipline after the 4/26/24 incident and were in-serviced, but shortly after that they both quit so the discipline did not mean anything. Surveyor asked if they have been able to get in touch with V13 or V14. V1 stated, no.

On 6/8/2024 at 1:02pm V19 stated, when a resident falls or is injured when using a mechanical lift, the nurse has to assess the patient, check range or motion, do vital signs and head to toe assessment, call doctor, if the resident is on blood thinners, the resident will be

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| S9999 | Continued From page 8<br>sent to the hospital, call family. We have to fill out risk assessment and complete the fall protocol and document in nursing notes what happened. Surveyor asked if the nurse is required to document in the medical record. V19 stated, "Yes, if not documented, it was not done". We have to also notify DON, supervisor, and family.<br><br>Surveyor attempted to call V13 and V14 on 6/8/2024 without a response. During the course of the survey, V13 and V14 failed to returned surveyor's call.<br><br>During course of survey, facility did not produce any evidence/documentation regarding staff training/education regarding the use of mechanical lift/injury prevention.<br><br>(A) | S9999 | | |