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
	IL6002364	A. BUILDING: ______ B. WING ______	C 10/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE CARE CENTER	1701 NORTH BOWMAN DANVILLE, IL 61832

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S 000	Initial Comments Complaint #1866346/IL106113	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b)5) 300.1210d)6) 300.3240a) 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 each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each	S9999	**Attachment A** **Statement of Licensure Violations**	

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resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

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.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These Regulations were not met as evidence by:

Based on record review and interview, the facility failed to safely transfer a resident (R3) by full mechanical lift from the bed to a wheelchair. This failure resulted in an angulated distal tibial fracture of the right leg. R3 is one of three residents reviewed for mechanical lift transfers in the sample of 4. This past noncompliance occurred from 06/07/18 to 06/15/18

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Findings include:

R3's Physician Order Sheet dated 91/18 - 9/30/18 documents the following: Down Syndrome, Moderate Intellectual Disabilities, Morbid Obesity, Anxiety Disorder, Age Related Osteoporosis Without Current Pathological Fracture, and Unspecified Fracture of Lower End of Right Tibia.

R3's Minimum Data Set (MDS) dated 04/10/2018 (prior to 6/7/18 fall) documents R3 as being severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 6 out of 15. This same MDS documents R3 requires extensive physical assistance of two person for transfers.

R3's Fall Risk Assessment dated 1/4/18 (most recent, prior to fall 6/7/18) documents R3 as High Risk for falls.

R3's Mobility Assessment dated 4/4/18 documents R3's requires Sling (full mechanical) Lift for transfers.

R3's Care Plan dated 4/10/18 (prior to 6/7/18 fall) documents the following: (Mechanical Lift) Transfers with two assist.

R3's Progress Note dated 6/7/18 at 5:55 pm signed by V12, Registered Nurse (RN) documents the following: "Initial observation of resident; At 5:50 pm was called to nursing station by east wing (unidentified) CNA (Certified Nursing Assistant) stating resident (R3) had slipped out of (mechanical lift) sling at 5:25 pm (25 minutes prior to being reported) onto the floor. Assessed immediately reveal (revealed) resident (R3) lying in bed trembling, stating 'my leg hurts'. Physical Assessment (pain, ROM, injury); Resident (R3)

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was lying in beg (bed) with (R3's) hand on upper right thigh. Skin was intact. ROM (range of motion) of upper extremities was normal movement. Did not manipulate lower extremities due to complaint of pain. Cause; Possible improper use of (mechanical lift)." The same Progress Note documents V3, Primary Care Physician was notified and gave a new order to send R3 to the emergency room for further evaluation.

On 9/27/18 at 10:57 am V12 acknowledged the above progress note and added the following information: V12 stated R3 continued to have pain in R3's full right leg after returning from the hospital emergency room on 6/7/18. V12 also stated R3's ankle was red upon R3's return from the hospital on 6/7/18. V12 stated R3's leg progressed to incorporate edema and bruising that extended mid foot up over the ankle for the next three days.

V10, Certified Nursing Assistant's (CNA) Fall Investigation Witness Statement dated 6/7/18 documents the following: " I (V10) and (V9, CNA) were transferring (R3) from bed to chair and (R3) slide (slid) out of the sling. We (V9 and V10) didn't retrieve (get) a nurse right away. We (V9 and V10) got (R3) up in bed, after 15 minutes we spoke to (V8, RN)." V10 and V9 are no longer employed at the facility.

V9, CNA's Fall Investigation Witness Statement dated 6/7/18 documents the following:" I (V9) came in at 5:00 pm, entered (R3's) home 'room' and started to get (R3's) roommate (unidentified) in chair (roommate) was prep (preparation) already. Once (roommate) was in the chair, I (V9) started on (R3). I (V9) changed (R3) and placed (R3) on top of the (full mechanical lift) sling. I (V9)

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turned around (to) comb (roommates) hair, I (V9) grabbed (R3's) chair, other CNA (V10) had (R3) in the air. (V10) pulled (R3) away from the bed and (R3) slid out of the bottom of (full mechanical lift) sling onto the floor."

R3's undated Investigation Follow Up Report documents the following: "the sling (full mechanical lift) was to go between (R3's) legs. (R3) can not tolerate this technique. Current practice is to cross the sling behind (R3's) knees. (V9, CNA) put sling behind (R3) then (V10, CNA) hooked sling to (mechanical lift) not realizing sling was not crossed. When they (V9 and V10) raised (mechanical lift) (R3) slid to the floor."

Additional information was noted in R3's fall investigation from (V9's) "Employee Memorandum; Progressive Discipline Form" dated 6/12/18 documents the following: On 6/7/18 you assisted (R3) transfer in which the straps of the (mechanical lift) sling were not crossed over. During the transfer the patient (R3) slid out. Following the fall you assisted (R3) to bed prior to notifying the nurse. This is not the proper procedure for patient transfers and is not the proper procedure to be followed following a fall."

R3's Emergency Room Provider Note dated 6/7/18 documents R3 was evaluated after a fall from (mechanical lift) for constant right leg pain. The same report documents R3's hips and pelvis were x-rayed and there was no femoral neck fracture noted. R3's lower extremities were not x-rayed at this time.

R3's Nurse Progress Note dated 6/7/18 at 11:26 pm documents R3 returned by ambulance on a stretcher, from the emergency room.

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On 6/8/18, there were no Nurse Progress Notes documenting a post fall assessment on R3 from any shift. In addition, there are no skin assessments to indicate if R3 had discoloration to the right lower leg.

R3's Nurse Progress Note dated 6/9/18 at 12:19 pm documents the following: "Nurse from (local hospital) emergency room called, reported no recent fractures to hip and pelvis."

R3's Weights and Vital Summary documents R3 continued to complain of pain 6/7/18 - 6/14/18 at levels varying between two of ten (mild) to six of ten (moderate). R3's corresponding Medication Administration Record documents R3 was receiving Morphine Extended Release 15 milligrams routinely in the morning and Hyrdrocodone 10 milligram - Acetaminophen 325 milligrams routinely at bedtime.

R3's Nurse Progress Note dated 6/9/18 at 1:24 pm documents the following: "(R3) status post fall second day. Fall precautions observed. (R3) complained of right hip and both feet pain, as needed pain medication give (given)."

On 6/10/18 and 6/11/18 on all shifts, there were no Nurse Progress Notes of R3 being assessed post fall or skin assessments to indicate if R3 had discoloration of R3 right lower leg.

On 6/12/18 at 12:09 pm Nurse Progress Note documents (R3's) right foot was swollen and bruising noted by R3's ankle "yellow in color". "(R3) complained of pain and as needed pain medication given." The same Note documents (unidentified) Physician notified and X-rays were ordered.

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R3's Physician Order Sheet dated 6/12/18 documents to obtain an x-ray of R3's right leg, ankle, and foot.

On 6/15/18, R3 was evaluated by V11, Orthopedic Surgeon. V11's Progress Note documents R3 was transported by the facility after an x-ray on 6/12/18 (5 days after fall) of R3's right femur, tibia, knee, ankle, calcaneus and foot. The 6/12/18 x-ray documents an angulated distal tibia fracture acute in nature. The same progress note documents the facility did not send the x-ray disc for V11 to review. V11 repeated the above x-rays and confirmed R3's acute distal tibia fracture. The same report documents the following plan: "(R3) is not an operative candidate, (R3) needs to have the fracture in her right leg protected and immobilized with a fracture brace. (R3) is not a great candidate for surgical intervention for sure because of (R3) medical problems and nonambulatory status."

V3, R3's Primary Care Physician's "Nursing Home Documentation Form" signed by V3, dated 7/18/18 documents the following: " (R3) fell last 6/7/18 and sustained an angulated distal tibial fracture of right leg. (R3) has seen Orthopedic Surgeon (V11). No surgery or casting. On boot (boot on)."

The facility Hydraulic Lift (full mechanical lift) policy dated 8/25/15 documents the following: "Policy: All Nursing staff will be trained on the proper use of the hydraulic (full mechanical lift) lifts that are used within the facility, to ensure safe transfer for residents. (Full mechanical lifts 0 will be used as ordered and per nursing judgement." The same policy documents: " Positioning sling under resident from lying down position. (bed or

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S9999	Continued From page 7 floor): 7. Ensure sling is centered under resident. 8. Pull leg straps under resident's thigh, ensure not (no) twisting has occurred. 9. Repeat procedure with other leg. 10. Criss cross the leg straps as shown with one strap passing through the other. 11. Prepare resident for transfer by attaching sling to (full mechanical lift) lift. The same policy documents the following: Lifting and transferring resident: Prior to lifting an individual make sure that the straps of the slings are securely placed on the hooks on the carry bars." Prior to the survey date, the facility took the following actions to correct the noncompliance: 1. QA (Quality Assurance) meeting was held on 06/11/18 with a plan of action put into place. 2. C.N.A.'s involved in the incident were re-educated and recieved disciplinary action on 06/12/18. 3. (Mechanical lifts) transfer competencies were completed on 06/14/18. 4. Nursing staff were re-educated, completed on 06/15/18 on proper transfers and on not to move residents in any circumstances until the nurse has assessed them. (B)	S9999		