| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| S 000 | Initial Comments<br><br>Complaint Investigation #2042402/IL121481 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br><br>300.1210 b)<br>300.1210 d)6)<br>300.3240 a)<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<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>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>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>Section 300.3240 Abuse and Neglect<br>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.<br><br>These regulations are not met as evidenced by: | S9999 | **Attachment A**<br>**Statement of Licensure Violations** | |

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Based on observation, interview, and record review, the facility failed to provide safe transfers for 2 of 8 residents (R220, R232) reviewed for falls in the sample of 32. This failure resulted in R220 sustaining a shoulder fracture.

Findings include:

1. R220's face sheet documents R220 was admitted to facility on 2/17/2020 with a diagnosis of END STAGE RENAL DISEASE, ATHEROSCLEROTIC HEART DISEASE OF NATIVE CORONARY ARTERY WITHOUT ANGINA PECTORIS, HEMIPLEGIA, UNSPECIFIED AFFECTING LEFT NONDOMINANT SIDE, DIFFICULTY IN WALKING, MUSCLE WASTING AND ATROPHY, and DISORDER OF FACIAL NERVE.

R220's Care plan, dated 2/24/2020, documents: Fall Risk: (R220) has a history of falls. He is dependent on a mechanical lift for transfers, and is wheelchair bound. History of stroke 2008 with left side hemiparesis 6/15/2020 Fracture to right shoulder acromion. Has had minimal complaints of pain. INTERVENTIONS: 02/24/20-Therapy to continue to work on transfers 06/19/20-mechanical lift for all transfers r/t (related to) R. (right) shoulder fracture. 3/10/2020 changed on 06/19/20 (mechanical) lift for all transfers.

R220's Nurses note, dated 6/15/2020 12:00pm, Health Status Note documents: This writer received a self reported fall from patient at this time. Patient (R220) stated that he fell during transfer last night and got back to chair with mechanical lift. No injuries but c/o (complaint of) pain to right shoulder. RUE (right upper extremity)

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limited ROM (range of motion) per norm but he stated right shoulder is sore. MD (medical doctor) made aware, administered (acetaminophen) and placed order for X-ray at this time.

Facility's investigation report, dated 6/15/2020, documents: (R220) self reported a fall and expressed pain in the right shoulder. Physician and POA (Powere of Attorney) notified. Order received for an X-ray. DON (Director of Nursing) and Administrator have been notified. On 6/15/2020 resident reported to staff nurse that he was experiencing pain to right shoulder as a result of a fall that occurred the previous night 6/14/20. Staff and resident interviews conclude that resident's right upper extremity became unsupported during a sit to stand transfer and that staff assisted to complete transfer safely resulting in the resident being seated on the floor.

R220's Nurses note, dated 6/16/2020 01:28am, Health Status Note documents: (R220) has Right acromion fracture. Lateral displacement of the distal fracture fragment is identified related to a fall on 06/14/2020. POA (power of attorney) and Dr. notified of the results.
Waiting on a call back from the MD. Patient denies pain or any discomfort at this time.

R220's Nurses note, dated 6/18/2020, documents: 6/14/2020 9:00 PM Health Status Note Late Entry: Note Text: CNA (Certified Nursing Assistant) notified this writer, the resident is on the floor. He did not fall, (I) the CNA lowered him to the floor. This writer talked to the resident, He confirmed, he doesn't have any pain, he was not injured anywhere. He did protest going to bed and not in his chair.

On 8/12/2020 at 09:40 AM, R220 stated, "I told

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them (staff) the higher I am up in the sling the safer I am." R220 stated, "I fell and broke my shoulder." R220 is alert and oriented and answers questions appropriately.

On 8/12/20 at 12:51 PM, V33, Licensed Practical Nurse (LPN), stated, "When I was giving his (R220) morning medication, (R220) stated, "Can I have a pain pill?" "My right shoulder got caught in sling and I fell all the way to the floor." V33 stated, "(R220) is dead weight." V33 stated, "I was surprised because (R220) is with it, he knows what is going on." V33 stated, (Night agency nurse V34), "She was an agency Nurse (V34), I don't know if she knew she had to report this or if she knew what a fall was." V33 stated, "I received no report that (R220) had fallen." V33 stated, "I immediately notified my manager and ordered an X-ray." V33 stated, "Staff was to only use a mechanical Sit to Stand if bedside commode was right next to resident's bed." V33 stated, "I haven't seen that Agency Nurse (V34) since the incident." V33 stated, "(R220) is the type of person that doesn't bother you." V33 stated, "I asked my aide if she got any report and she stated, she did." V33 stated, "The night CNA was (V35) and my CNA was (V36).

On 8/12/20 at 3:02pm, V35, CNA, stated, "(R220) is not stable on the sit to stand." V35 stated, (R220) is a heavy man. V35 stated, "I was transferring (R220) back to bed and he stated, "Hurry up, I'm going to fall." V35 stated, "I had to wipe him clean." V35 stated, "(R220) stated again, 'Hurry up I'm going to fall'." V35 stated, "Then (R220) let go." V35 stated, "I was able to catch (R220) so that he didn't slam to the ground." V35 stated, "I got another CNA and the Nurse (V34). V35 stated the sit to stand is not made for (R220) that can't stand. V35 stated,

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"Multiple times we told nurses and they don't do anything." V35 stated, "I didn't report it to dayshift CNA, I reported it to my nurse (V34)." V35 stated, "I doubt if that agency nurse (V34) still works there." V35 stated, "I had heard that (R220) has fallen in the shower before." V35 stated, "(R220) had to have 2 staff with him in the shower because he was afraid of falling." V35 stated, "I would probably use a mechanical lift next time." V35 stated, "Physical Therapy never worked with me, to train me to use the sit to stand for (R220)."

On 8/12/2020 at 3:25PM, V36, CNA, stated, (R220's fall) wasn't reported. V36 stated that she asked R220, "Did ya fall yesterday?" V36 stated, "(R220) stated something about sit to stand didn't move fast enough and he slipped out." V36 stated, "A lot of the girls were intimidated with using sit to stand."

On 8/17/2020 Attempts to call R220's Physician (V38) were made and no return calls received.

The facility's Employee Disciplinary Action Form for V34, dated 6/16/2020, documents V34 received a Verbal Warning for Failure to document a resident incident.

2. R232's Care Plan, dated 5/12/2020, documents "(R232) is at risk for falls due to forgetful, unsteady at times, incontinent of urine, tries to get up without help at times, weakness and history of fall. ADL (activities of daily living) Self Care Performance Deficit related to admit 11/28/18 after hospital stay, weakness & unsteady, some confusion and may attempt to get up without help. Unable to perform ADL's independently. Deficit: Unsteady on feet, tires easily, poor balance. Apply gait belt, have her

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| S9999 | Continued From page 5<br>push up from surface and grasp walker to gain balance.<br><br>R232's Minimum Data Set (MDS), dated 5/12/2020, documents "Extensive assist of 1 for transfer."<br><br>R232's transfer assessment, updated 3/2020, posted on closet door documents "Stand and Pivot transfer with gait belt. With assistive device-Walker"<br><br>On 7/20/2020 at 11:40 AM, V5, Registered Nurse (RN), assisted R232 from the toilet to her recliner. V5 grabbed R232's left arm and assisted her to a standing position from the toilet. V5 pulled up R232 pants. R232 began wavering her body back and forth grabbing the wall and walker. V5 grabbed R232's arm and assisted her to the recliner. V5 did not apply gait belt prior to transfer and ambulation.<br><br>The Facility's Fall Assessment and Management Policy and Procedure, dated 4/2019, documents, "It is the policy of this facility to assess each resident's fall risk on admission, quarterly, and with each fall. This will help facilitate an interdisciplinary approach for care planning to appropriately monitor, assess and ultimately reduce injury risk. Factors related to the risk will be addressed and care planned."<br><br>(B) | S9999 | | |