STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009377	A. BUILDING: _____ B. WING _____	C 10/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRACE NURSING HOME,THE	1615 SUNSET AVENUE WAUKEGAN, IL 60087

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S9999	Final Observations Statement Of Licensure Violation: 1 of 1 Violation 300.610a) 300.1210b)5) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

care and personal care shall be provided to each 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.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)

These Requirements are not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure residents were transferred in a safe manner for two of three residents (R1 and R2) reviewed for transfers in the sample of four. These failures resulted in R1 requiring 20 stitches on her right leg.

The findings include:

1. R1's computerized face sheet showed diagnoses including wedge compression fracture of T9-T10 vertebra, malnutrition, anorexia nervosa, osteoporosis, rheumatoid arthritis, osteoarthritis, weakness, and history of falls. R1's facility assessment dated July 31, 2019 showed

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S9999	Continued From page 2	S9999		

no cognitive impairment. The facility assessment showed R1 required extensive staff assistance with bed mobility, transfers, dressing, toilet use, and hygiene.

R1's progress notes showed an incident note dated October 10, 2019 stating: "At 7:45 PM, CNA summoned this writer to report that the resident's right leg is bleeding. Resident was sitting on her bed, her right lateral lower leg sustaining a long cut and is bleeding moderately ...The cut measured 15cm (centimeters) in length, unable to assess how deep ..."

R1's October 2019 physician order sheet showed an order dated October 10, 2019 to: "Send to (local emergency room) for treatment of wound sustained to R (right) side of lower leg."

On October 17, 2019 at 10:15 AM, R1 was lying in bed and not covered with any blankets. R1 had a white gauze bandage wrapped around her right lower leg. The bandage covered her calf from the bottom of her knee to the top of her ankle. R1 stated her leg was injured while being transferred out of the wheelchair and into bed. R1 said just one CNA (Certified Nurse Aide) moved her. R1 stated she told the aide to use the machine (mechanical lift) or get another staff member to help. R1 said the aide replied, "No, I can do it." R1 said the aide picked her up and put her on the bed. R1 said her leg hit the metal bar of her bed and started bleeding all over the place.

On October 17, 2019 at 10:45 AM, V3 (CNA) stated R1 is transferred using a mechanical lift. V3 said R1 cannot bear weight on her feet at all. V3 said R1 has declined in her ability to stand and has used a mechanical lift for all transfers for about the last one month. V3 said the restorative

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S9999	Continued From page 3	S9999		

nurse (V4) determines transfer needs for residents.

On October 17, 2019 at 11:00 AM, V4 (restorative nurse) stated R1 needs a mechanical lift for all transfers because she cannot bear weight due to chronic back pain. V4 said R1 is "very sharp" cognitively and definitely able to make her needs known to staff.

On October 17, 2019 at 12:45 PM, V5 (CNA that transferred R1) stated she moved R1 by herself (on October 10, 2019). V5 said she grabbed R1 by the elastic waist band on her pants and "bear hugged" her. V5 said she lifted R1 up slightly by her pants to get her body onto the edge of the bed. V5 said R1 was not able to stand on her feet. V5 said she was unaware R1 was bleeding until R1 said, 'Ouch my leg." V5 said she saw blood on R1's right leg and the skin was torn open about the length of a pencil. V5 said she believed R1's leg hit the metal side rail when V5 lifted R1 onto the bed. V5 said she thought R1 was a one assist for transfers and she moved R1 into bed by herself.

On October 17, 2019 at 1:50 PM, V3 (CNA) stated all residents' capability levels for ADLs (activities of daily living) are documented on their daily ADL check list, which is completed daily for every shift. R1's ADL check list was reviewed with V3 for the month of October 2019. The check list showed R1 marked as a 3/3 for transfers (extensive assist with staff providing weight-bearing support/ two person physical assist) for 8 of the 19 entries including October 9, (the day before the leg injury). V3 said ADL performance levels are charted on resident care cards so aides know exactly how to care for residents. R1's care card was reviewed with V3

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S9999	Continued From page 4	S9999		

present and was blank for all care areas, including transfers. V3 said the care card has been blank since R1 was admitted in May of 2019.

On October 17, 2019 at 2:00 PM, V4 (restorative nurse) was shown R1's ADL check list and care card. V4 said she did not realize R1's care card was blank. V4 said the care cards are used to communicate to staff how to safely and correctly care for residents. V4 said the 3/3 documentation of R1's ADL checklist indicates she needs a mechanical lift for transfers. V4 said R1 cannot put the pressure of standing on her legs or feet due to pain.

On October 17, 2019 at 2:50 PM, V2 (Director of Nurses) stated resident care cards are important so staff know individual resident needs. V2 said it is an important form of communication and every resident should have one.
The facility's Transfer Techniques policy dated 5/10 states under the general instructions section: 4. Obtain help when necessary, or as identified on care plan/care card.

R1's fall care plan was reviewed and did not show any interventions indicating how R1 should be transferred. R1's skin care plan was reviewed and showed a focus area related to fragile skin and precautions needed. Interventions included: "Mechanical lift to transfer. Date initiated October 15, 2019" (five days after R1's leg injury).

R1's October 10, 2019 emergency room instructions showed a discharge diagnosis of "skin avulsion" (wound that happens when skin is torn from your body during an accident or other injury).

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S9999	Continued From page 5	S9999		

R1's facility Final Investigative Report dated October 16, 2019 showed R1 "was transferred to the ER for further evaluation where she received 20 stitches and was then returned ..." (on October 10, 2019).

2. R2's Admission Record printed 10/17/19 by the facility shows diagnoses including Alzheimer's disease, dementia, depressive disorder, hypertension, and metabolic encephalopathy. The facility assessment dated 8/13/19 shows R2 has severe cognitive impairment and requires extensive assist of one staff member for bed mobility, dressing, toileting, personal hygiene and bathing. The assessment shows R2 requires extensive assist of two for transfers and his balance is not steady; only able to stabilize with staff assistance.

On 10/17/19 at 11:44 AM, V6 Certified Nursing Assistant (CNA) was transferring R2 from his wheel chair to his bed via a sit to stand mechanical lift. As V6 was raising R2, R2 raised and bent both legs so his feet were about one foot off of the stand lift. V6 instructed R2 to put his feet back down. R2 put his feet down, however, both feet were hanging halfway off of the tray of the stand lift. V6 pushed the stand lift over to R2's bed and lowered him down.

At 12:22 PM, V4 (Restorative Nurse) said during a sit to stand transfer, the resident's feet should not be hanging half-way off the stand. The resident could get an injury from doing that. V4 said when transferring a resident using the sit to stand lift, their feet should be all the way on the stand. At 2:52 PM, V2 Director of Nursing said the resident's feet should be on the stand during a sit to stand transfer. At 3:00 PM, V6 said when transferring a resident by the sit to stand lift, the

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S9999	Continued From page 6 resident's feet should be completely on the stand tray, not hanging half-way off the tray. R2's Activities of Daily Living care plan with a revision date of 8/13/19 shows "Transfer: The resident requires mechanical aid sit to stand for transfers." The facility's undated Transfer Program Policy and Procedure show "To ensure safe and appropriate transfer techniques for resident per regulatory guidelines and professional standards of practice ...Mechanical Assisted Transfers: Sit to Stand Lift Transfer: B. To be transferred with a sit to stand lift, the resident must have no medical contraindications for using the lift. The resident should have the following characteristics: Alert ...Able to follow simple commands." (B)	S9999		