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
	IL6001135	A. BUILDING: _____ B. WING _____	C 12/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST CITY REHAB & NRSG CTR	321 ARNOLD AVENUE ROCKFORD, IL 61108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Final Observations Statement of Licensure Violations 300.690 b) 300.690c) Section 300.690 Incidents and Accidents b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, " serious " means any incident or accident that causes physical harm or injury to a resident. c) The facility shall by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only " means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional, it shall notify the Department ' s toll- free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. This REQUIREMENT was not met as evidenced by: Based on observation, interview and record review the facility failed to report serious incidents to the regional office within 24 hours of occurrence. This applies to 2 of 3 residents (R2 and R3) reviewed for injuries in the sample of 7. The findings include: 1. On December 12, 2015 at10:10 AM, R2 was sitting in his wheelchair with Left leg elevated on his wheelchair leg rest. R2 stated " I hurt my knee. I fell and broke it. "	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 12/29/15

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An incident report dated October 26, 2015shows R2 had fallen to one knee while walking and smoking outside in the smoking area. On October 27, 2015, R2 ' s left knee had increased swelling. The results of knee x-ray showed fracture of Left patella. R2 was sent to a local hospital on the same day. R2 went back to the facility and was awaiting surgery for Open Reduction and internal fixation (ORIF) of the Right Knee. R2 underwent ORIF on November 9, 2015.

On December 12, 2015 at 9:45AM, E1 (Administrator) said we did not report this incident to IDPH. The previous Director of Nursing considered it as a non reportable occurrence.

2. On December 12, 2015 at 12:00PM, R3 was up in his wheelchair. His Right foot was resting on his leg rest. R3 said his right foot got caught in his mattress during a transfer. R3 said his right foot is broken.

R3 ' s Progress notes dated October 31.2015 showed " R3 ' s rigR3 ' s Progress notes dated October 31.2015 showed " R3 ' s right foot got caught in between bed frame and mattress .... Certified Nursing Assistant (C.N.A.) staff and nurse lifted the mattress off of resident ' s foot. R3 was complaining of pain. Nurse Practitioner was notified and ordered x-ray. "

On November 1, 2015 the final radiology report result showed " Fracture Right foot. "

On December 12, 2015 at 11:40AM, E1 (administrator) stated " we were so busy investigating this incident involving R3 we forgot to report this to IDPH. "

The Facility policy for Accidents and Incident Reporting dated December 2013 states f: The Department of Public Health will be notified of any serious accidents or incidents in accordance with the Skilled Nursing and Intermediate Care facilities.

(AW)

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600.610a)
300.1210b)
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 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

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S9999	Continued From page 3 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. (Section 2-107 of the Act) These requirements were not met as evidenced by: Based on observation, interview and record review the facility failed to ensure that resident was transferred in a safe manner to avoid injury. This failure resulted in R3 sustaining a fractured right foot on October 31, 2015. The facility failed to maintain mechanical lifts in good repair. This applies to 2 of 3 residents (R3, R7) reviewed for safety in the sample of 7. The findings include: 1. The Physician order sheet (POS) dated December 2015 shows R3 has Diagnoses that include Traumatic Brain Injury and Fractured Right foot. The Minimum Data Set (MDS) dated September 2015 shows R3 is total dependence of physical assist of two or more staff with transfers. The Nurses Notes dated October 31, 2015 documented that E8 (Certified Nursing Assistant (CNA) called E3, License Practical Nurse (LPN) to R3's room. R3 was in bed, in supine position. R3's right foot was caught between the bed frame and the mattress. According to E8, he transferred R3 to bed per mechanical lift by himself. On December 12, 2015 at 12:00 PM, R3 was by the nurse's station sitting up in his wheelchair. His	S9999		

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right foot was resting on his leg rest. R3 said his right foot got caught in his mattress while being transferred to bed. R3 said his right foot is broken.
On December 12, 2015 at 11:55 AM, E2 Director of Nursing said, E8, Certified Nursing Assistant (CNA) was fired because E8 ' s stories were not matching up. E2 stated " we were investigating and reinvestigating this incident. When R3 was being put to bed, E8 was by himself. (R3 is a two person assist and Mechanical Lift) E2 said R3's Mattress moved in the process of the transfer. R3's foot got stuck between the bed frame and mattress. When R3 was rolled over in bed, it twisted R3's foot and R3 sustained a fracture.
On December 14, 2015 at 9:20 AM E3 Licensed Practical Nurse (LPN) said he was the nurse when this incident happened. E3 said he was informed by E8 (CNA) to go to R3's room. E3 said when he got to the room, R3 was in bed. E3 said he did not remember seeing a mechanical lift in the room. E3 said he was more concerned about R3 ' s foot being stuck between the mattress and the bed frame. E3 said E8 told him he transferred R3 by himself.
On December 14, 2015 at 10:00AM, surveyor and E1 went to R3's room. E1 (administrator) showed the surveyor R3 's mattress. E1 said the investigation revealed that R3 was transferred from the shower cart to bed. E8 performed a one person transfer to R3 from the shower cart to the bed. E1 said the air mattress was not fastened to the bed, the air mattress slid off partially from the bed. E1 said R3's right foot was trapped between bed frame and mattress, E8 rolled R3 to his side. R3's right foot was twisted and caused R3's right foot fracture.

Z1 stated she does not understand how it

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S9999	Continued From page 5 happened. Z1 said she was told R3's foot caught in the bed. Z1 stated "I ordered an x-ray. R3 has a right foot fracture. R3 has been under the care of an orthopedic Doctor." The Final Radiology Report dated October 31, 2015 showed an Acute Right foot fracture. The Facility Policy Entitled Mechanical Lift states 1. A Mechanical lift should be used ...two staff members required for the procedure. 2. On December 14, 1915 at 9:30AM, E5 & E6 Certified Nursing Assistants (CNA) transferred R7 using a mechanical lift and with a full body sling. The mechanical lift used by E5 and E6 was missing a hanger bar latch. E6 stated, "we have two lifts, I know one was missing the hanger bar latch." On December 14, 2015 at 2:08 PM, E1 said, mechanical lifts should not be used without the hanger bar latch, the mechanical lift should be repaired. On December 15, 2015 at 10:56 AM, Z2 mechanical sling lift manufacturer stated, the hanger bar latch is part of the bar to attach the sling, it should be used when transferring a resident. (B)	S9999		