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
	IL6002760	A. BUILDING: _____ B. WING _____	C 11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN VILLAGE HEALTH FACILITY	267 EAST LAKE STREET BLOOMINGDALE, IL 60108

(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
Z9999	FINDINGS STATEMENT OF LICENSURE VIOLATIONS Section 350.3240 Abuse and Neglect a) An owner, Licensee, Administrator, employee or agent shall not Abuse or Neglect a resident(Section 2-107 of the Act) (A,B). Based on record review, observation and interview, the facility failed to follow its policy to prevent abuse and neglect for 1 of 1 incident of a fall from a mechanical lift, involving R2. R2 fell from the mechanical lift when staff neglected to follow their own transfer policy. R2 fell from the lift, hitting her head, sustaining a laceration to the left forehead, and a fracture to her left distal femur. Findings include: The facility PYA Clinical Practice Guidelines entitled, "Hydraulic or Total Lift", dated 03/14, was reviewed. It reads, but is not limited to, " Purpose: 1. To lift and move a resident safely. Equipment: 4. A properly trained staff member cannot operate the hydraulic/total lift by him or herself. A minimum of 2 staff members is required to operate the hydraulic/total lift for a resident's transfer. Procedure: 4. Position the hydraulic/total lift so the frame can be centered over the client... 6. One staff member is to focus on the resident head and body positioning while the other is operating the lift...7. Spread the legs of the machine around the chair or under the bed. In the event when the bed or chair prevents the spreading of the machine legs, the lift can be used safely with the legs closed and then spread when away from the bed or chair. 8. Carefully	Z9999	Attachment A Statement of Licensure Violations	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 11/27/15

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wheel resident in hydraulic/total lift away from the bed, supporting the limbs as needed. Position over chair, and gently lower to chair using the hydraulic mechanism by pressing the "down" button. 9. To properly position the resident in chair, lower resident until their bottom touches the seat of the chair. At the time, continue lowering the resident, while at the same time pull up on the sling's positioning handle(not backwards or towards yourself)."

The facility Resident Safety Precautions dated 4/22/15 were reviewed. It discusses multiple precautions, including, but not limited to the following, "It is the responsibility of every employee to provide the safest possible environment for our residents. The guidelines listed below, though not all inclusive, are to be followed. Many of our residents have muscular skeletal limitations resulting in poor balance, trunk control and posture as well as decreased strength and coordination. Because of these limitations it is very important to: Be sure to check the resident's transfer status in the resident's Plan of Care or with the nurse prior to transferring a resident...Use two staff members when using a mechanical lift...General Precautions * If a fall does occur, don't move the resident until the nurse has first assessed the resident's condition."

The incident report involving R2, dated and timed 11/4/15 at 7:00am was reviewed. It reads, but is not limited to, "NOC nurse reported that resident fell during a transfer from hoyer(mechanical lift) to wheel chair. Assessed resident while laying in bed at 7am. and noted L(left) side of forehead open area measuring 1/3cm x .2 cm and (starts) swelling around affected area....noted remained conscious, alert and responsive when resident's name is called. No grimacing noted during

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assessment but c(with) occasional crying noted....Hospital diagnosis: Fx(Fracture) to left distal femur."

R2's IPP(Individual Program Plan) dated 9/29/15 was reviewed. It reads, but is not limited to, "Transfers: Wheel chair-bed and Sit-Stand: Dependent(2 or more person lift transfer or mechanical lift) Less than 100 lbs but poor tolerance to manual lift for transfers - primarily lift-Chair needs to be tilted back before sling transfer for safety."

R2's PT/OT Assessment dated 9/15 was reviewed. It reads, but is not limited to, "Resident transfer, w/c to bed or bed to w/c- dependent - 2 or more person lift or mechanical lift. Resident does not bear weight and weighs over 50#, but no more than 100#. Comments: Less than 100 lbs but poor tolerance to manual hold for transfers-primarily lift. Chair needs to be tilted back before sling transfer for safety. Current wt(weight) 87.1 lbs."

R2 was observed on 11/13/15, lying in her bed, with staff reading to at bedside. R2 was observed with a splint noted to her left leg, and per staff is on bedrest at this time.

R2's medical/programming chart was reviewed. R2 was readmitted to the facility after her fall with the following orders related to her left femur fracture, per review of her Physician Order Sheets dated 11/9/15:

* X-ray of left femur in 4 weeks
* Left leg splint in place, continue per ortho
* Non Weight Bearing to Left Lower Extremity
* Low pressure air loss mattress
* No shower, bed bath only

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Z9999	Continued From page 3 * Norco as needed for pain every 4-6 hours * Doxycycline 100mg(milligrams) every 12 hours for 10 days * Cefdinir 300mg(milligrams) twice per day for 10 days * Follow up with ortho MD in 3 weeks The Investigation of Incident involving R2, for the incident of 11/4/15 at 7:00am was reviewed. The incident states that R2 fell to the floor during a mechanical lift transfer from bed to wheelchair at approximately 7:00am. R2 sustained a laceration to her forehead with some swelling but never lost consciousness and was acting her usual self. She was assessed by the nurse, and no other visible injuries were identified. She was sent to the ER for evaluation, and was admitted with a diagnosis of Left Distal Femur Fracture, Head Injury, Pain Control and Facial Pain. Her assigned aid was suspended at the time of the occurrence, pending investigation. E4(Habilitation Aid) was the aid that was assigned to care for R2 the morning of 11/4/15. E4 was interviewed on 11/4/15 by both E1(Administrator) and E5(Director of Nursing), after the incident occurred. E4 explained to both E1 and E5 that she always conducts transfers from the mechanical lift from the front(of the wheelchair) but on the date of this incident, she attempted transfer to R2's power wheelchair from the rear side. While she was lowering R2 onto the wheelchair, she tried to maneuver R2's body forward into the seat. While doing so, the sling became crooked and the resident fell out of the sling onto the floor. During the interview, E4 explained that at the time of the incident, another aid was in the room,(E6), assisting another resident. Immediately after the fall, E4 asked E6 to get the nurse. E4 then lifted R2 from off of the	Z9999		

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Z9999	Continued From page 4 floor, and onto her bed. E4 stated that she was aware of the fact that she should have put the lift in front of the wheelchair for transfer and that she should have had a second person assisting her with the transfer. E4 also indicated that she knows she was not supposed to lift the resident after a fall, but explained that at the time of the incident, she panicked, and in an attempt to help R2, she lifted R2 and transferred her to her bed. E4 stated this was the first time she ever attempted to transfer R2 from the side of her wheelchair. She expressed she had no idea why she attempted the transfer this way, but just decided to try it. E4 stated that as soon as she realized it was not going to work, she tried to move the lift to the front of the chair, but as she moved the lift, R2 fell. E4 also expressed during the interview that she uses the lift on her own when she is working with "smaller" residents. She said if the residents are heavy, she then asks for someone to help her. E4 stated she felt she could do R2's transfer on her own because she is "smaller". She expressed she could have asked E6 for help, but at the time didn't think she needed help, and thought she was fine on her own. Review of E4's personnel file revealed she was in fact trained on safe resident handling policy upon hire, and completed competency testing on 4/27/15, and was deemed competent in conducting safe transfers using the mechanical lift. At the time of the training, E4 was able to demonstrate the need to have a second caregiver provide assistance in addition to demonstrating a clear understanding of the protocol for a resident found on the floor. E4 was also at this time, deemed capable of performing the skills necessary for conducting a safe resident transfer when using a mechanical lift.	Z9999		

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E2(Registered Nurse) was also interviewed after the incident. E2 was the nurse assigned to care for R2 the morning of 11/4/15, and was just finishing with report from the noc nurse, when she was called in to see R2 because she had fell. E2 reported that her initial observations identified R2 to be bleeding from the left side of her head. E2 stated that R2 was not grimacing at the time, but was occasionally crying. E2 explained that her primary focus was to focus on R2's head injury, so she placed a cold compress on R2's head. E2 stated that she did not do a head to toe assessment at this time, because R2 sustained a head injury, and she knew that R2 would be going out the the hospital for a thorough evaluation.

The conclusion of the investigation states that R2 fell from the mechanical lift during a transfer from her bed to her wheelchair. It was determined, after investigation, that E4 was not utilizing the mechanical lift per facility policy at the time of the incident. E4 remained suspended during the investigation, and was terminated on 11/9/15.

During an interview with E1(Administrator) on 11/12/15 at 9:30am, E1 was asked if she did the investigation involving R2's fall from the mechanical lift. E1 confirmed that she did the investigation, and stated that E4 had explained to her, and demonstrated to her how she performed the transfer of R2 on 11/4/15. E1 stated that E4 positioned the mechanical lift from the side, and not the front of R2's wheelchair. E1 stated that when E4 went to lower R2, she was trying to maneuver her position, because the sling was not correctly positioned over the chair. As E4 lowered R2 into the chair, the slack of the sling opened up enough to allow R2 to slip out of the sling, and fall onto the floor. E1 stated that E4

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Z9999	Continued From page 6 thought she could perform the lift by herself because R2 is light, but admitted that she knew proper transfer technique is always to have two staff perform a mechanical lift transfer. E1 confirmed that E4 knew not to pick up a resident after a fall, until she could be assessed by a nurse, but E4 stated she panicked, and picked R2 up off the floor, and placed her on her bed. E1 stated that she terminated E4, and re-trained all other staff with a return demonstration. E1 stated they are continuing to monitor, by performing spot checks while staff are performing mechanical lift transfers, to ensure all staff continue to use proper technique. (B)	Z9999		