

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6002612</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/24/2017</b>
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NAME OF PROVIDER OR SUPPLIER  <b>DUPAGE CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>400 N COUNTY FARM RD WHEATON, IL 60187</b>
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S 000	Initial Comments  Complaint Investigation #1771607/ IL92601	S 000		
S9999	Final Observations  Statement of Licensure Violations:  300.610a) 300.1210b) 300.1210c) 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	S9999	<h2>Attachment A</h2> <h3>Statement of Licensure Violations</h3>	

Illinois Department of Public Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

04/13/17

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S9999	<p>Continued From page 1</p> <p>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.</p> <p>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</p> <p>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:</p> <p>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.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a)An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>These requirements were not met as evidenced by:</p> <p>Based on observation, record review and interview the facility failed to ensure staff monitored residents (R1 through R4) to prevent from sustaining injuries when staff transferring</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>residents who are dependent on staff for their safe transfer from bed to chair and or from chair to bed. The facility also failed to implement interventions per their plan of care.</p> <p>As a result:</p> <p>(1) R1 sustained a laceration to her scalp and fractured left proximal tibial metaphysis and fibular neck when staff transferred her on March 13, 2017 from bed to motorized chair with total mechanical lift.</p> <p>(2) R2 sustained left intertrochanteric hip fracture when staff transferred him on March 12, 2017 from bed to wheel chair with a sit to stand mechanical lift.</p> <p>(3) R3 sustained left 4th toe fracture when staff transferred her on March 20, 2017 with a total mechanical lift from wheel chair to bed.</p> <p>This applies to 4 of 4 dependent residents (R1 through R4) evaluated for injuries sustained when the staff transferred these residents.</p> <p>The findings include:</p> <p>(1) R1's Nurses Notes on March 14, 2017 showed she was being transferred with sit to stand mechanical lift on March 13, 2017 at 6:00 AM and accidentally hit her head on the mechanical lift where she sustained a laceration to the posterior right occipital area. The laceration required seven staples and she also sustained a 3.0 cm (centimeter) x 2.0 cm bruise to her right ear.</p> <p>R1's Nurses Notes on March 15, 2017 at 11:10 AM showed, she complained of left leg pain during her transfer, noted bruise on her left lateral knee 3.0 cm x 3.0 cm and left lateral leg 10.0 cm x 5 cm. March 15, 2017 X-Ray showed subacute</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>slightly displaced fracture involving the left proximal tibial metaphysis and fibular neck. The fracture may represent pathologic fractures due to unspecified lucency.</p> <p>The facility on March 13, 2017 6:00 AM documented the incident "towards end of transfer to chair using mechanical lift with two Certified Nurse Aides (CNAs) R1's upper body unexpectedly moved and R1 hit head onto part of the mechanical lift machine, sustained 1.5 cm laceration to back of head with moderate amount of bleeding and bruise to right ear." The incident investigation report noted E3 and E4 (CNAs) were involved in transferring R1 on March 13, 2017. The facility's investigation of the incident did not determine the cause of the incident.</p> <p>On March 19, 2017 E3 gave written statement to the facility as part of the incident occurrence. In the statement E3 stated E4 assisted to transfer R1. E4 operated the mechanical lift and E3 guided R1's feet towards her chair. R1 suddenly flipped upside down and R1 was hanging down. E3 and E4 managed to put R1 back in the bed. R1 hit her head on the bottom of the mechanical lift when she was hanging. E3 stated all four sides straps of the sling still attached to the mechanical lift and not sure what went wrong. E4's written statement also confirmed E3's statement.</p> <p>The facility per her February 20, 2017 Minimum Data Set (MDS) Brief Interview for Mental Status (BIMS) score of '15,' meaning R1 to be alert and oriented to time, place and person.</p> <p>On March 21, 2017 at 3:30 PM R1 stated there was only one CNA (E3) who transferred her.</p> <p>On March 22, 2017 at 12:20 PM in the presence of E10 and E11 (Nurses) R1 stated it was only E3</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>who transferred her. On March 23, 2017 at 9:00 AM in the presence of E8 and E15 (CNAs) R1 stated E3 transferred her and after she fell, E4 came to help to put her back on the bed. The facility incident investigation documents that R1 stated E3 and E4 transferred her. R1's CNA care guide for transfer showed to use mechanical lift with two person assist.</p> <p>According to the (mechanical lift) Manufacturer's guide line and the facility mechanical lift policy and procedure, it shows to use medium size sling for a person whose weight is between 90 - 220 pounds. R1's weight record showed she weighs 144.5 pounds. R1 falls into medium sling range. The intervention of using medium size sling is not documented in the CNA care guide or on her plan of care for fall prevention.</p> <p>On March 23, 2017 9:00 AM E8 (Restorative Aide) and E15 (CNA) transferred R1 from bed to motorized chair with mechanical lift using medium size sling. E8 stated they could use medium or large for R1. It is unknown what size sling the staff used when transferring R1 on March 13, 2017 when the incident occurred.</p> <p>On March 23, 2017 at 11:25 AM, Z2 (direct care physician and Medical Director of the facility) per telephone stated that R1 has Cerebral Palsy, contractures to upper and lower extremities and has spasticity. Z2 said, sometimes when position is changed spastic movements may trigger, but the staff has to monitor her movements. Z2 said, R1 may have had a spastic movement, another reason could be the way the aides hooked the sling to the mechanical lift. They may have hooked it wrong.</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>(2) R2's March 12, 2017 9:44 AM nurses notes showed E6 (CNA) heard 'pop' sound when he transferred resident from bed to wheel chair with a sit to stand mechanical lift. R2 complained of pain to his left knee. X-Ray of left knee was negative for fractures. On March 13, 2017 change of condition report for R2 showed he was in severe pain to left leg, hip, unable to move, positive for external rotation, guarding site, sent to the hospital for evaluation and treatment.</p> <p>On March 13, 2017 at the hospital X-Ray of left hip showed R2 sustained acute left femoral neck fracture with lateral and anterior angulation of distal fracture fragment. On March 14, 2017 at the hospital R2 underwent open reduction and internal fixation of the left hip.</p> <p>The facility documented the incident of March 12, 2017. E7 (Nurse) in the incident documented 'per CNA (E6), while transferring R2, he was yelling and kicking. After transferring, R2 complained of left knee pain.</p> <p>During the facility investigation of the incident E6 gave a written statement stating "during resident care and transfer R2 was uncooperative and resistive with the process of care and transfer. E6 transferred R2 with sit to stand lift. During the process of hooking R2 up to the machine he was pushing and kicking the machine several times, and after the completion of the transfer to his wheel chair he started complaining of left knee pain."</p> <p>R2's March 7, 2017 fall injury care plan interventions included "when R2 show signs of agitation and being resistive to care, allow R2 time and re-approach at later time." This</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>intervention was not followed on March 12, 2017.</p> <p>On March 21, 2017 at 2:45 PM E6, Restorative CNA stated the unit is usually supposed to have three CNAs plus himself (E6) for day shift and evening shift. On March 12, 2017 day shift, two CNAs called in sick and there was only one CNA plus himself for 18 residents. E6 transferred R2 with mechanical sit to stand from bed to chair. R2 has Dementia, was resistive to care and transfer, he kicked and pushed the mechanical sit to stand, resisted to apply the harness. E6 said with much difficulty was able to apply the harness, but E2 continued to push and kick the sit to stand lift and E6 heard a 'pop' sound on his left leg. E6 managed to complete transferring R2 from the bed to wheel chair. E6 also stated, he could not wait and re-approach or get extra help due to being short of help.</p> <p>On March 24, 2017 at 10:45 AM E6 and E13 (CNA) transferred R2 from bed to wheel chair with a mechanical lift. R2's CNA care guide showed transfer with one person assistance. E13 stated prior to R2's injury it was one staff transfer and the care guide needs to be updated.</p> <p>On March 23, 2017 Z2 stated R2 has Dementia and Anxiety. The staff should allow time when R2 is resistive to care and re-approach later. It is normal for someone to point to their knee when they have hip injury. The staff should have done X-Ray of leg, knee and hip, in this case the hip X-Ray was done a day later. Z2 assured he will work with the staff, it is quite unusual for the facility to have such incidents.</p> <p>(3) The facility documented an incident involving R3, when the staff (E5 and E14 both CNAs)</p>	S9999		
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S9999	<p>Continued From page 7</p> <p>transferred her with a mechanical lift from her wheel chair to the bed. Her foot was caught on the mechanical lift which resulted in a laceration to R3's left 4th toe. The X-Ray showed left 4th toe fracture.</p> <p>On March 22, 2017 at 3:10 PM E5 stated E14 was driving the mechanical lift machine, she (E5) was at the foot end. When E14 lifted R3 with the mechanical lift, R3's foot bumped into the machine. E5 said, she should have been careful, especially R3 being unable to help and totally dependent on staff.</p> <p>R3's current physician orders showed she has Multiple Sclerosis, Spastic Quadriplegia, Morbid Obesity and Dementia.</p> <p>On March 23, 2017 at 11:25 AM Z2 stated the aides should be more careful and monitor residents during transfer, so the injuries could be prevented.</p> <p>(4) On March 22, 2017 at 2:30 PM R4 stated on March 19, 2017 early in the morning (Z1) an agency CNA got her (R4) up from bed with a gait belt and dropped (R4) on the floor and Z1 fell on top of her. R4 said, she is supposed to be up with a sit to stand lift mechanical lift, due to her (R4) left sided weakness from Cerebral Vascular Accident (CVA). R4 said that Z1 insisted she can do by herself.</p> <p>R4's March 16, 2017 CNA care guide showed she is supposed to be transferred with a sit to stand lift with one staff assistance. On March 19, 2017 Z1 did not follow the CNA care guidelines to transfer R4 from bed to wheel chair.</p> <p>On March 23, 2017 at 4:30 PM E2 (Director of</p>	S9999		

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S9999	<p>Continued From page 8</p> <p>Nurses) stated Z1 is a CNA from the agency and she was not sure if Z1 was tested for competency for the use of the mechanical lift.</p> <p>R4's admission record showed she was admitted to the facility on October 4, 2016 with multiple diagnoses including CVA with left sided weakness and leg neuropathy.</p> <p>R4's January 24, 2017 fall risk care plan showed she has a history falls and was found on the floor 14 times (December 8, 9, 18, 20, 21, 23, 2016; January 1, 15, 31, 2017; February 4, 6, 12, 23, 2017; and March 8, 2017.)</p> <p>(A)</p>	S9999		