

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6006761	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/02/2017
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NAME OF PROVIDER OR SUPPLIER HOPE CREEK CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4343 KENNEDY DRIVE EAST MOLINE, IL 61244
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S 000	Initial Comments Incident Report Investigation to Incident's of: 1/26/2017/IL92024 1/25/2017/IL92023	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 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	S9999	<p>Attachment A Statement of Licensure Violations</p>	

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

TITLE

(X6) DATE

03/17/17

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S9999	<p>Continued From page 1</p> <p>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>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 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 record review and interview the facility failed to maintain a safe mechanical lift transfer for one of three residents (R1) reviewed for falls in a sample of three. This failure contributed to a fall with a Right Supracondylar Femur Fracture, which required an Right Above the knee Amputee.</p> <p>Findings Include:</p> <p>The facility policy titled, Using A Portable Device dated 11/7/2014 documents, "The primary purpose of using portable</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>lifting machine is to help lift residents who may be too heavy to lift. The portable lift is also used to promote comfort and to maintain good body alignment while the resident is being moved."</p> <p>According to a History and Physical, dated 1/27/2017, R1 has a very complicated past medical history which includes an infected Right Total Knee Arthroplasty, which persisted, was taken out, but a spacer was left in. Coronary Artery Disease, Chronic Obstructive Pulmonary Disease, Right Distal Femur Fracture above the cement spacer, and Anxiety.</p> <p>R1's Careplan dated 1/19/2017 documents, "Falls: The resident (R1) has had an actual fall where she (R1) slid from her(R1) mechanical lift while being lifted to the toilet on 12/27/2016 (While not a resident). Also, documents that resident (R1) fell out of the hoyer when being put to bed at bedtime. She (R1) has a Right AKA (Above the Knee Amputee.) Careplan also documents resident will transfer with 3:1 mechanical transfer, using a mechanical lift and an extra large full body sling. R1's Careplan documents, Mood:She (R1) is tired a lot and scared of falling again. Resident (R1) is depressed and only thinks of loss of her(R1) leg/unfairness of it."</p> <p>The MDS (Minimum Data Set) dated 2/14/2017, assesses R1 to be totally dependent on staff, requiring two persons physical assist for transfers. MDS also shows R1 requires two persons physical assist for toileting and bed mobility.</p> <p>R1's Nurses Notes dated 1/26/2017 at 8:30PM documents, "CNA (Certified Nursing Assistant) called RN (Registered Nurse) to room 3101,</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>stating that resident (R1) had fallen to the floor from a mechanical lift. Resident (R1) on floor laying on left side. Family (Granddaughter) was in room when incident occurred. Granddaughter states that CNA'S properly had resident (R1) in mechanical lift but, that resident (R1) jerked and sling slipped off mechanical lift, causing resident (R1) to fall. No visible injury noted. Resident complained of right lower extremity pain. Doctor notified. Ordered to send to emergency room to evaluate and treat."</p> <p>According to the emergency department Physicians Notes dated 1/26/2017. History of Present Illness. The patient (R1) presents with fall. Onset: 1/26/2017. Pt.(R1) is a resident of a local nursing home. Granddaughter states she (R1) was at bedside when she (R1) was dropped. Family reports she (R1) was being lifted with a mechanical lift by nursing staff when the strap of the mechanical lift came undone and patient (R1) fell straight to the floor. Family states her (R1) right leg hit the mechanical lift during the fall and then hit the floor. Patient (R1) is complaining of right leg pain.</p> <p>R1's Radiology results, dated 1/26/2017 at 1:29PM from the local emergency room documents "Right leg emergency room interpretation: Spiral fracture of the distal Femur extending to the joint line."</p> <p>R1's Physician's Progress Notes dated 1/27/2017 from the local hospital documents" Impression : 1. Right Periprosthetic Femur fracture with a history of recurrent infections, to the knee." Plan: I sat down with resident(R1) and family and discussed her clinical situation. Advised her(R1) that supracondylar femur fractures are most commonly treated with</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>plate fixation or some medical device to restore stability. However, she (R1) would be at significant risk for reactivation of infection in the area of her knee and her fracture, which does extend down to her antibiotic spacer. I advised her that plate fixation of her fracture would be associated with significant risk of reactivation of infection...I discussed another option, which would be above-knee amputation. I feel that above the knee amputation is the most safe way of trying to control her pain and morbidity associated with this fracture given the chronic infection of knee...After a lengthy discussion with her(R1) and her(R1) family, she(R1) has elected to continue with the surgical plan of above-knee amputation.</p> <p>The facility witness statement written by E4/CNA (certified nursing assistant) dated 1/26/2017 at 8:30PM documents "Resident anxious, shifted her weight in sling when this happened resident's front left side of sling came out causing resident to fall to floor."</p> <p>On 2/28/2017 at 10:10 AM, E6/CNA (certified nursing assistant) stated, "Resident was being transferred from wheelchair to bed with a full sling mechanical lift. Resident (R1) was very anxious and tense. Because of another incident in another nursing home. Resident(R1) was uncomfortable and fidgety. Resident's(R1) body position was kinda shifting and leaning toward the left side. The other CNA and I attached the straps to the mechanical lift, we lifted resident(R1) out of wheelchair, not very far up, then placed resident(R1) back down, because resident(R1) was asking, "Am I on correctly", "Am I on correctly". So, we checked connections again to reassure the resident (R1). We lifted the resident (R1) back up again, then removed the wheelchair</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>from underneath her (R1) and guided her towards the bed. As, I went around the bed with resident(R1) ,the left side loop just "dropped" from the left metal hook causing resident(R1) to fall out of the mechanical lift sheet and fall to the ground.The resident(R1) was leaning toward the left side, causing sling strap (loop) to "snap" out of the hook. I feel, that if the resident(R1) was not leaning toward the left side, and wasn't having so much anxiety and tension, that it wouldn't have caused "a tip" to the bar, that caused the loop to disengage from the hook. Causing resident(R1) to fall to floor."</p> <p>On 2/27/2017 at 3:15PM, E4/CNA(certified nursing assistant) stated, "We were transferring resident(R1) from chair to bed.Resident became very nervous when using mechanical lift.Because prior to admission resident(R1) had a fall involving a mechanical lift in another nursing home. Resident(R1) becomes anxious anytime she(R1) uses a mechanical lift, everyone knows that.Another CNA and I attached the straps to metal hooks and checked them. Didn't see anything wrong. We started to lift the resident(R1) and she(R1) became very anxious and nervous." Resident(R1) kept asking us "do you know what you are doing" We put her(R1) back down into wheelchair. Gave her(R1) the reassurance and lifted her(R1) up again. Resident(R1) remained very nervous causing her(R1) to shift her(R1) weight to the left side, causing the strap (loop) on the sling to disengage from metal hook, causing the resident(R1) to fall out of mechanical lift onto the floor. I think, because resident(R1) was so anxious and nervous because of the transfer it caused her(R1) weight to shift around."</p> <p>On 3/1/2017 at 8:25AM, Z3/R1 Granddaughter stated, "I was in the room when the staff was</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>transferring my Grandmother(R1) from the chair to the bed. I'veto never seen the horizontal bar (above head) move so much. It moved from side to side to up and down. The staff had to hold the bar during transfer because it almost hit my grandmother(R1) across the face. My grandmother(R1) kept saying over and over again, "something doesn't feel right, something doesn't feel right". I did notice that she(R1) was sitting back more then usual. All attachments looked right, from where I was standing. But, my Grandmother(R1) didn't feel comfortable. Staff knows that she(R1) gets very anxious everytime she(R1) gets moved. She(R1) fell straight down on the floor, hit the mechanical lift and broke her(R1) right leg. It looked like the hook and the sling came undone."</p> <p>On 3/1/2017 at 10:00AM, R1 stated, "I am nshot real sure what happened, it all happened so fast.I do know I fell out of the mechanical lift and broke my leg and I had to have it cut off. I am not a suing a person but, someone should pay for this. I kept telling the CNA's (Certified Nursing Assistants) it didn't feel right, (transfer). "</p> <p>On 3/1/2017 at 11:30AM, E2/DON (Director of Nursing) stated, "Anxiousness,rigidity,anxiety,resident being on her left side, and the hook/clip are contributing factors that caused the resident(R1) to fall from the mechanical left and sustain a fracture of the right leg. Reapproaching resident(R1) does not work, she(R1) will still have anxiety."</p> <p>On 3/1/2017 at 9:40AM, E3/ Restorative Director stated, "It is the responsibility of the CNA's (certified nursing assistant) to be inspecting the mechanical lift, including the metal hooks/with attached clip to ensure that the clip is close to the</p>	S9999		

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S9999	Continued From page 7 hook. There is a potential that the loop on the sling can go underneath the clip and detach from the hook causing the resident(R1) to fall.It is possible, that could have been the problem with the residents(R1) mechanical lift." On 3/1/2017 at 2:30PM, Z2/ Distributor for mechanical lift stated," There is a safety device on the metal hook(cradle) its function is to assist in keeping the sling on the cradle. With the patient(R1) in the sling,elevated off the surface, the weight of the patient(R1) will force the loops of the sling into the curve position on the cradle (hook.) If the sling is installed correctly on the cradle it will not come off the cradle,when the patient(R1) is on the sling and elevated.It is made so that the sling does not come out.The proper intended position is for the sling to be directly under the knees up to the shoulders, in a semi reclining position supported by the sling. If not positioned correctly, depending on the resident,they would be subject to a higher incident of injury." On 3/1/2017 at 8:00AM, Z1/Physician stated, " The fall from the mechanical lift caused the resident(R1) to fracture the right leg. (A)	S9999		