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
	IL6000012	A. BUILDING: ______ B. WING ______	04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A MERKLE C KNIPPRATH N H	1190 E 2900 NORTH ROAD CLIFTON, IL 60927

(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	S9999		

Licensure Violations:
300.1210b)
300.1210c)
300.1210d)6
300.1220b)3
300.3240a)

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.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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 nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.1220 Supervision of Nursing

Attachment A
Statement of Licensure Violations

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000012	A. BUILDING: ___ B. WING ___	04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A MERKLE C KNIPPRATH N H	1190 E 2900 NORTH ROAD CLIFTON, IL 60927

(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	Continued From page 1	S9999		

Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident

These Regulations are not met as evidenced by:

Based on observation, record review and interview, the facility failed to provide safety and supervision to prevent falls by failing to provide safe transfer with a sit to stand lift, failing to thoroughly investigate incidents, identify root cause, and implement new interventions. These failures affect three of six residents (R15, R1, R2) reviewed for falls in the sample of 13. Failure to provide a safe lift transfer for R15 resulted in a right fractured fibula, causing pain and requiring

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
	IL6000012	A. BUILDING: ______ B. WING ______	04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A MERKLE C KNIPPRATH N H	1190 E 2900 NORTH ROAD CLIFTON, IL 60927

(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	Continued From page 2	S9999		

an orthopedic brace.

Findings include:

1. On 4/24/17 at 10:00am, E2 (Director of Nursing/DON) reported that E15 had a fall in the shower on 4/22/17 due to the hook coming off the sit-to-stand, and received an ankle fracture.

According to the undated electronic diagnosis list, R15 has been at the facility since 2003, with multiple diagnoses including Cerebrovascular Accident, Alzheimer's, and Arthritis. Minimum Data Sets (MDS) for 1/16/17 and 10/17/16 assess R15 as moderately cognitively impaired, non-ambulatory, and requiring extensive to total assistance of two staff for bed mobility, transfers, toileting and bathing. No transfer assessment was in the record.

Nursing Notes dated 4/22/2017 state that E13 (Registered Nurse/RN) responded to a call for assistance in the shower room, where E13 found E11(Certified Nurse Aide/CNA) and E12 (RN) were "holding on to the resident." Nursing Notes state that R15 was being transferred from the toilet to the wheelchair per sit -to -stand lift when "the loop of the transfer belt that connects to the lift came disconnected on the left side. {R15's} right foot was still on the foot slot of the lift and the right loop of the transfer belt was still connected to the lift." The notes continue that R15 was transferred to the wheelchair and then to bed per full mechanical lift, at which time R15 complained of ankle pain when removing her shoe. A portable x-ray was completed that day as ordered. When the portable x-ray showed a right distal fibula fracture, Z4 (on-call physician) ordered R15 to be sent to the hospital for treatment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000012	A. BUILDING: ____ B. WING ____	04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A MERKLE C KNIPPRATH N H	1190 E 2900 NORTH ROAD CLIFTON, IL 60927

(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	Continued From page 3	S9999		

Nursing Notes state R15 returned to the facility that evening of 4/22/17 at 7:00pm, with a molded soft cast and orders for Norco (narcotic analgesic) as needed. The hospital x-ray report dated 4/22/17 notes a "nondisplaced oblique hairline fracture of the distal fibular diaphysis." This x-ray also documents decreased bone density and degenerative changes.

On 4/24/17 at 11:30am, R15 stated that when the incident occurred, the CNA was getting her up from the toilet when "the lift broke", in that one side of the sling came off the lift. R15 said her foot hurt and they found out it was broken. R15 said there was one person helping her, then more nurses came in to help. On 4/26/17 at 10:30am, R15 stated she did not recall the incident clearly and did not recall if she stood up quickly while on the lift. R15 stated that "it hurts" especially with movement and she receives pain medication.

On 4/26/17 at 10:10am, E11 CNA stated that she normally uses the sit to stand lift by herself for R15 for showers and toileting. E11 stated and demonstrated that she connected the waist sling and the loops over the knobs as usual. E11 stated R15 was able to bear weight with both feet and hold onto the handles only with her right hand. At the time of the incident, E11 stated and demonstrated as R15 had been on the toilet and was in a semi-standing position, when R15 suddenly came up to a standing position "with a lot of force", causing on the left loop on the knob come loose from the knob. E11 said R15 had a habit of "popping up" quickly. E11 stated R15 fell toward her right side, but still holding onto the right handle bar, so R15 did not go down to the floor. E11 called for help, and E12 and E13

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
	IL6000012	A. BUILDING: ____ B. WING ____	04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A MERKLE C KNIPPRATH N H	1190 E 2900 NORTH ROAD CLIFTON, IL 60927

(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	Continued From page 4	S9999		

responded, assisting E11 to lower R15 to the floor. Using the full mechanical lift, these staff lifted R15 to the wheelchair, and then to the bed. During this time, E11 stated R15 was saying, "my foot." Then when R15's shoe was removed, R15 complained of pain.

On 4/26/17 at 10:50am and 1:05pm, E12 and E13 respectively, each confirmed the nursing notes and information provided by E11, that they responded to call for help, and that R15 was still holding on, connected to the sling on the right side. E12 and E13 stated they thought that the sit-to-stand lifts could usually be used by one staff person.

On 4/26/17 at 12:10pm, E4 (Careplan Coordinator) confirmed that R15 was assessed as requiring two assist for transfers and toileting. E4 also confirmed that R15's last careplan dated 1/25/17 instructed staff to use the mechanical lift to get out of bed and the sit-to-stand lift for toileting. The intervention does not specify one or two assist. E4 also stated that usually the sit-to-stand can be used by one person, unless the resident is heavy, due to staff hurting themselves. E4 stated she was not aware of R15 "popping up" quickly on the sit-to-stand, but that the full mechanical lift was to be used when getting R15 up from bed due to "abrupt movements."

On 4/26/17 at 12:30pm, E2 DON stated she was aware that R15 had a pattern of standing up quickly in the sit-to-stand. E2 stated that E11 should have used two staff for R15's sit-to-stand transfer from the toilet to the wheelchair. E2 stated she started that practice when she started as DON, that two people are required for all lift transfers - mechanical and sit-to-stand. E2 stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000012	A. BUILDING: ___ B. WING ___	04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A MERKLE C KNIPPRATH N H	1190 E 2900 NORTH ROAD CLIFTON, IL 60927

(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	Continued From page 5	S9999		

that Therapy would be who assessed R15 for transfers, but did not know if R15 had one. E2 stated she was not sure if the facility had a written policy regarding using to staff for mechanical transfers. No written policy was provided, nor was a transfer assessment for R15.

On 4/26/17 at 3:15pm, Z1 (physician) confirmed that R15's fibula fracture was most likely from the incident on the lift on 4/22/17, due to putting pressure on the right leg/ankle. Z1 stated R15 had not been ambulatory in some time and had a degree of osteoporosis.

R15's transfers from bed to wheelchair and from shower chair to bed were observed on 4/25/17 at 11:55am and 4/26/17 at 9:50am respectively. Each time R15 cried out in pain with movement of the leg/foot. On 4/26/17 at 10:15am, a velcro orthopedic brace was reapplied as ordered at the Orthopedic office visit on 4/25/17, per physician's order.

Two undated User Manual and Owner's Operating Manual were provided for the sit-to-stand lift used for R15's transfer. Each manual includes the following under safety and general guidelines: "When elevated a few inches off the surface being transferred from and before moving the patient, check again to make sure the sling is properly connected to the attachment points of the stand up lift." Also, manual state that while the stand up lift "may be" operated by one staff person with a cooperative, partial weight-bearing patient. "However, since medical conditions vary, {manufacturer} recommends the the healthcare professional evaluate the need for assistance and determine whether more than one assistant is appropriate is each case to safely perform transfer. The use of the patient lift by one

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000012	A. BUILDING: ______ B. WING ______	04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A MERKLE C KNIPPRATH N H	1190 E 2900 NORTH ROAD CLIFTON, IL 60927

(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	Continued From page 6	S9999		

assistant should be based on the evaluation of the healthcare professional for each individual case."

2. The Minimum Data Set dated 2/13/17 documents that R1 is moderately cognitively impaired and requires extensive assistance with transfers and activities of daily living. The Physician's Order Sheet for 4/2017 documents R1 has diagnoses of Difficulty Walking, Muscle Weakness and Dementia with Behavioral Disturbance and that R1 receives Risperidone (antipsychotic) 0.5 milligrams (mg) at bedtime.

The Final Report dated 3/24/17 documents on 3/18/17 at 12:10 AM R1's bed alarm was sounding and R1 was found on the floor by the bed. The Report documents that R1 stated to staff that R1 was up from R1's bed because R1"had to pee". The Report states an X-ray completed on 3/20/17 documents that R1's left femur was fractured.

The 3/24/17 Report documents that on 3/3/17 R1's Risperidone was decreased from 0.5 mg to 0.25 mg at bed time and after the decrease R1's restless behaviors such as getting out of bed returned so on 3/16/17 R1's Risperidone dose was increased back to 0.5 mg. at bed time. The Report documents that R1's restless behaviors had not subsided when R1 fell on 3/18/17.

R1's Care Plan dated 3/24/17 documents the following fall prevention interventions: "(R1) uses a wheelchair for long distance mobility", "NWB (non weight bearing) status r/t (related to) hip fracture", "monitor for safety-monitor applied to bed/chair" and "3/18/17 - X-ray reveals (L) hip fx (fracture)." The Care Plan does not document a new intervention after the 3/18/17 fall

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000012	A. BUILDING: ______ B. WING ______	04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A MERKLE C KNIPPRATH N H	1190 E 2900 NORTH ROAD CLIFTON, IL 60927

(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	Continued From page 7 implemented to reduce the severity of a fall or prevent R1 from falling or indicate that R1's Risperidone was increased (3/16/17) due to R1 becoming restless and attempting to get out of bed. On 4/25/17 at 12:10 PM E2 Director of Nurses stated that the root cause of R1's fall was increased agitation resulting from the decreased dose of Risperidone. At that time E2 reviewed R1's Care Plan and confirmed that the care plan does not include a new intervention implemented after R1 fell or document information related to managing R1's restless behaviors with Risperidone. (B)	S9999		