STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014195	A. BUILDING: _____ B. WING _____	C 06/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY OF BUFFALO GROVE	150 NORTH WEILAND ROAD BUFFALO GROVE, IL 60089

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S 000	Initial Comments Complaint 2114193/IL134998 F689J cited	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b)5) 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 which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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. Restorative measures shall include, at a minimum, the following procedures: 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. 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 300.3240 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)	S9999		

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S9999	Continued From page 2 These Regulations were not met as evidenced by: Based on interview and record review, the facility failed to perform a safe transfer with a mechanical lift for a resident (R1) reviewed for falls, 1) failed to train staff on mechanical lift emergency procedures and the facility failed 2) to ensure the safety of a resident during a pivot transfer for 2 residents (R1, R3) reviewed for falls. This failure resulted in R1 sustaining a right clavicular fracture, right femoral fracture, and a humeral (upper arm) fracture and expiring 48 hours after her fall, and R3 sustaining a tibia and fibula fracture of her leg. The findings include: 1. R1's electronic face sheet printed 6/23/21 showed R1 had diagnoses including but not limited to dementia with behaviors, morbid obesity, heart failure, muscle weakness, and edema (swelling). R1's facility assessment on 6/6/21 showed R1 was a two person assist for transfers and toilet use and required a mechanical lift. R1's fall risk assessment dated 4/13/21 showed R1 was a high fall risk. R1's Restorative/Mobility Screen dated 6/6/21 showed, "Toilet use: Extensive x 2 person assist at times." R1's documented weight in the facility dated 5/2021 showed R1 weighed 285.1lbs.	S9999		

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S9999	Continued From page 3 R1's care plan dated 5/7/21 showed, "The resident has an activities of daily living self-care performance deficit related to dementia and muscle weakness. Toilet use: The resident requires extensive assist with 1-2 staff participation to use toilet. Transfer: The resident requires extensive staff assistance with 2 staff participation with transfers using a mechanical lift." R1's fall event dated 6/12/21 showed, "Resident using (mechanical lift) in bathroom. Resident calling "help,help!" Alert, resident did not hit her head, ambulation status was assist of one with or without the device, unable to complete assessment of range of motion, no rotation/deformity/shortening, laceration on right lower leg." R1's emergency medical services record from local emergency transportation company dated 6/12/21 showed, "Patient was found on the floor wedged underneath the toilet and against the wall. Staff on scene stated they were helping patient using a lift when the patient fell onto the floor. Staff stated the patient cut her leg open on the bottom of the lift that had an exposed screw head sticking out ...Patient was awake and screaming at the crew. Patient stated both her shoulders and her leg hurt. Patient stated she remembers the fall...Secondary trauma assessment revealed a laceration above the right ankle, a large contusion to the right side of the patient's forehead, and pain upon palpation of patient's right knee." R1's trauma history and physical note from the local hospital dated 6/12/21 showed, "Right lower extremity rotated and immobile, several small	S9999		

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S9999	Continued From page 4 contusions. Right shoulder, right upper arm, left shoulder and left knee tender to palpation and bruised." R1's imaging reports from the local hospital dated 6/12/21 showed, "There is a soft tissue laceration overlying the right frontal bone. There is a nondisplaced mid-shaft fracture of the right clavicle. There is a fracture of the distal right femoral diaphysis (shaft) with fragment displacement by 3.5cm. There is a nondisplaced fracture of the mid right humeral diaphysis. Diffuse soft tissue swelling in the medial aspect of the distal right leg." R1's laceration repair notes from the local hospital dated 6/12/21 showed, "10cm x 5cm laceration to right lower leg repaired with 10 sutures." R1's inpatient progress notes from local hospital dated 6/13/21 showed, "Hemorrhagic shock (severe blood loss) secondary to trauma. Treatment for sepsis." R1's Inpatient Discharge Summary/Expiration Note from the local hospital dated 6/14/21 showed, "Patient was admitted to the trauma team with lacerations, right femur fracture, right humerus fracture and right clavicular fracture ...She was started on zosyn for sepsis coverage although sepsis was unlikely ...she continued to worsen and required more oxygen. The critical care team had goals of care discussions with the son and was notified she was actively dying. She became more bradycardic (decreased heart rate) and died at 11:05AM on 6/14/21." R1's discharge diagnosis list from the local hospital showed R1 was discharged with	S9999		

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S9999	Continued From page 5	S9999		

diagnoses including but not limited to fall with multiple fractures, multisystem organ failure, and shock.

R1's Certificate of Death dated 6/17/21 showed, "Date of injury: 6/12/21 due to a fall from a lift at the nursing home. Cause of death was noted as multiple injuries and fall. Manner of death was noted as "accident."

On 6/18/21 at 10:19AM, V7 (Registered Nurse) stated, "I was the nurse working the day that (R1) was sent to the hospital. I heard (R1) calling for help and when I went into the bathroom, (R1) was sliding out of the mechanical lift and (V4-Certified Nursing Assistant-CNA) told me the lift wouldn't lower (R1) down to the toilet. (R1) told me she needed help and was falling out of the sling. I called for help and (V6-CNA) came. I then ran out of the room to call a code blue to get as many staff members as I could to come help and when I came back into the room, (V6) told me he assisted (R1) to the floor and (V4) was not in there."

On 6/18/21 at 11:42AM, V2 (Director of Nursing) stated, "The mechanical lift that was being used for (R1) is not in use at this time. We found during our incident investigation that the remote was not working to raise and lower the resident." Observation of the mechanical lift that was used for R1 was made during this time and showed a strap located at the knee pad of the lift where the resident is supposed to have their legs strapped to prevent their legs from coming off of the lift.

On 6/18/21 at 12:21PM, V6 (CNA) stated, "I saw (R1) on the mechanical lift and she was halfway up and halfway down. We were trying to get her back on the toilet. I lowered her to the floor by the

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S9999	Continued From page 6	S9999		

toilet but I can't remember if anyone helped me or not. There is an emergency button on the lift but I don't think it works. There is a buckle on the mechanical lift sling that goes around the resident but we don't need a gait belt with these types of transfers."

On 6/18/21 at 12:30PM, V4 (CNA) stated, "I got (R1) on the mechanical lift because she insisted on going to the bathroom. I took her from her bed to the bathroom in the lift and then the remote would not work to sit her down on the toilet. I called for the nurse and she came in and told me to go get more help so I called (V6). I never saw (V6) assist (R1) to the floor. When I came back into the bathroom, (R1) was on the floor with her head and shoulders between the wall and toilet. There is an emergency button on the mechanical lift but I don't know how to use it. They trained me on the lift but nothing about what to do in an emergency or if the lift stops working. I have never used a gait belt on a resident during transfers with a sit to stand lift and I wasn't using one when I transferred (R1)."

On 6/18/21 at 1:16PM, V9 (Restorative Nurse) stated, "(R1) was labeled as an extensive assist with 2 staff at times. This means that a staff member may ask for assistance with (R1) if they are uncomfortable transferring her on their own. I asked for physical therapy to re-evaluate (R1) because I noticed that staff were asking for assistance more often when transferring her. I don't think we would ever use a gait belt for a mechanical lift transfer. If a mechanical lift quit working, I would unclip the sling with one staff member on each side of the resident and assist them to the floor or nearest surface. There is an emergency button that I suppose you could use to help lower the lift during a malfunction but I don't

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY OF BUFFALO GROVE	150 NORTH WEILAND ROAD BUFFALO GROVE, IL 60089

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S9999	Continued From page 7 know much about it." On 6/22/21 at 9:57AM, V7 (Registered Nurse) stated, "When I entered the room, (R1) was straight up in the mechanical lift and the lift sling was up around the front of her neck. I told (V4-CNA) to go get help and she left to get (V6-CNA). I left the room after (V4,V6) arrived and called a code blue. When I came back, (V6) was the only aide in the bathroom with (R1) and she was laying on her right side between the toilet and the wall with her head by the back of the toilet. I did not assess her except for her vital signs and blood sugar. There is an emergency release on the mechanical lift but I don't think (R1) was in a position where we could have used that because it would have taken too long." On 6/22/21 at 11:02AM, V6 (CNA) stated, "When I was called to (R1's) room, her feet were flat on the floor, she was not hanging onto the lift and her arms were up in the air. She was standing straight up, legs slightly bent. I took her right arm out of the sling and she dropped down a bit and then her left arm came out of the sling and she fell to her knees and twisted backwards and went down on the floor behind the toilet. Her lips were starting to turn blue when I was helping her. We usually use more than one person to transfer (R1) because she doesn't always bear weight. The emergency button on the lift could not be used because of the position that (R1) was in. I don't think it would have worked." On 6/22/21 at 12:31PM, V11 (Therapy Director) stated, "We used a mechanical lift for (R1) and were asked to evaluate her for her appropriateness in this lift because some of the aides were having doubts about transferring her because of her size and strength. We only did a	S9999		

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SYMPHONY OF BUFFALO GROVE	150 NORTH WEILAND ROAD BUFFALO GROVE, IL 60089

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S9999	Continued From page 8	S9999		

one-time assessment which means that we only did one transfer with her to see how she would do and she seemed okay with that transfer so we kept her as a stand lift. Again, this was a one-time assessment and we never saw her again. The safest way to transfer a resident with a mechanical lift is by going from one surface to another. It's risky to use it as a transport device because the resident can become weak and staff have less control if the resident begins to weaken before they reach another surface to sit them down on. If a lift malfunctions there is an emergency button that will bring the lift arms down so the resident can be safely seated on a surface."

On 6/22/21 at 2:31PM, V3 (Assistant Director of Nursing) stated, "I think the emergency button on the mechanical lift is to lower the resident down in an emergency but I'm not really sure. If a resident is stuck in the lift you could either take the resident out of the sling or use the emergency button. Either scenario would have the same outcome."

On 6/22/21 at 2:42PM, V2 (Director of Nursing) stated, "I did the incident investigation for R1's incident. (V4-CNA) was taking (R1) from her bed to her bathroom using the mechanical lift and when they got to the toilet, the lift would not go down. (R1) was all the way up in the lift standing straight up. (V4) called for assistance from (V7-RN) and was told to go get help from (V6-CNA). When (V6) entered (R1's) bathroom, her legs went under her and the lift sling was up under (R1's) arms and he couldn't lower the lift so he detached the sling and lowered her to the floor. I don't know how she sustained all of those injuries from being assisted to the floor. I don't know if the leg strap was behind her legs or not during the transfer. I would expect the aide to

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S9999	Continued From page 9	S9999		

take the resident out of the lift if it malfunctioned during a transfer. (V6) did not use the emergency release because it's too slow. I don't believe that the lift was being used as a transport device in this situation because it's not that far from (R1's) bed to her bathroom even though her bed was on the far side of the room."

On 6/22/21 at 3:01PM, V4 (CNA) stated, "I did not have the safety strap behind (R1's) legs during the transfer. I don't even know if I really ever use that. I know there was blood on one of the wheels from (R1's) leg but I don't know what exactly she cut her leg on. When I had (R1) in the lift, she was standing straight up, knees slightly bent. After I asked (V6) for help, he told me to leave (R1's) bathroom and go get more help. When I came back to the bathroom, (R1) was on the floor with her head and shoulders between the toilet and the wall. Had I been familiar with the emergency button I would have definitely used it in this situation. Now that I know what it's used for, it would have been completely appropriate to use in this situation. As far as I have been told, there is only one emergency button on the lift."

On 6/23/21 at 8:45AM, V5 (emergency room physician) stated, "When (R1) arrived at the emergency room, she was alert and oriented. She knew she was injured and she was in a lot of pain. She told me she fell out of the lift at the nursing home. She stated she was being helped into the bathroom and fell and was wedged between the wall and toilet. Her injuries were consistent with a traumatic fall, not an assisted fall. Even if you considered her diagnoses and diseases these injuries were significant and are consistent with a traumatic fall. Her injuries definitely contributed to her death, there's no question about it. I am still puzzled as to how

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 10	S9999		

those significant injuries were obtained while a resident was in a lift. The lifts are designed to be an added safety measure during transfers. This particular case is very clear to me and in my professional opinion it never should have happened."

The manufacturer's manual for the mechanical lift dated 11/2013 showed, "The patient lift is NOT a transport device. It is intended to transfer an individual from one seated surface to another (such as bed to wheelchair) ...Activating a Mechanical Emergency Release: Primary Emergency Release: This procedure will bring the boom (lift arms) down if the hand control is not functioning properly. To activate the emergency release, insert the tip of a pen into the Emergency Down hold in the control box. Secondary Emergency Release: All patient lift actuators are equipped with a mechanical emergency release. The mechanical release will enable the actuator to retract without power. Use the primary emergency release first before using the secondary emergency release. This procedure should only be used of the primary emergency release procedure is not functioning or is unreachable. To activate the secondary emergency release, pull up on the RED emergency grip and pull down on the boom (lift arms) at the same time."

The facility's undated policy titled, "Safe Patient Lifting Policy" showed, "The Safe Patient Lifting Policy exists to ensure a safe working environment for resident handlers ...Gait belt usage is mandatory for all resident handling with the exception of bed mobility and medical contraindications."

2. R3's electronic face sheet printed on 6/23/20

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S9999	Continued From page 11	S9999		

showed R3 was admitted to the facility with diagnosis including but not limited to emphysema, chronic diastolic congestive heart failure, intervertebral disc degeneration, muscle weakness, difficulty in walking, and unsteadiness on feet.

R3's care plan dated 6/23/20 showed, "The resident has an activities of daily living self care performance deficit related to weakness. The resident requires extensive assistance staff participation with transfers. May need 1-2 staff assistance at times."

R3's facility assessment dated 10/2/20 showed R3 was cognitively intact and required 2+ staff assistance for transfers.

R3's restorative/nursing assessment dated 10/2/20 showed R3 required 2 staff assistance for transfers and toileting.

R3's fall risk screen dated 10/2/20 showed R3 was a moderate fall risk, unable to independently come to a standing position, exhibited loss of balance while standing, and had decreased muscle coordination.

R3's nursing progress notes dated 10/11/20 showed, "Around 12:45PM the assigned aide came and called writer and reported that "Resident fell." When writer went into room, found the resident on the floor in her washroom, sitting on the floor on her buttocks, as per resident, "This girl was helping me to transfer from my wheelchair to toilet seat and my right leg gave up and I went down and I think I hurt my good knee."

R3's nursing progress notes dated 10/11/20 showed, "Around 1:10PM, the activity aide

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S9999	Continued From page 12	S9999		

brought resident back from a visit and said resident wants to see the nurse and wants Tylenol. Noted swelling on her left knee, transferred her back to bed, applied ice, and administered Tylenol. Obtained order for x-ray of left knee. X-ray results show acute comminuted fracture of the proximal tibia and fibula shafts are seen, there is some impaction and anterior displacement of the distal tibia shaft, moderate soft tissue swelling. Received order from physician to send resident to (local emergency room)."

R3's local emergency room records dated 10/11/20 showed, "Patient states earlier today she was in the bathroom when her other leg caused her to fall and twist the injured leg. Immediate severe pain, tried Norco and Tylenol without relief. Now swollen with bruising. Pain worse with movement, cannot ambulate...Imresssion: left tibial fracture, closed fracture of proximal end of left fibula."

On 6/24/21 at 8:05AM, R3 stated, "The day I fell I was in the bathroom and the aide said she knew how to transfer me and apparently she didn't. Instead of putting my wheelchair behind me she pushed it further away and then told me to sit down so I did and then I fell to the floor because there was nothing behind me. There was no gait belt on me and there was only 1 aide assisting me. Usually they used 2-3 staff members to tranfer me but this girl said she knew how to do it herself so I trusted her. I shouldn't have trusted her because I haven't walked since and I was able to walk before."

On 6/24/21 at 8:10AM, V14 (certified nursing assistant-CNA) stated, "Before her fall, I think (R3) was a 1 assist for transfers. We should

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014195	A. BUILDING: _____ B. WING _____	C 06/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYMPHONY OF BUFFALO GROVE	150 NORTH WEILAND ROAD BUFFALO GROVE, IL 60089

(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 13 always be using a gait belt for transfers because if a resident starts to fall you have something to hold onto. If you don't use a gait belt and a resident starts to fall then you have no way to try and prevent them from falling." On 6/24/21 at 8:25AM, V10 (CNA) stated, "A gait belt should be used for all transfers except mechanical lift transfers. If you don't use a gait belt then the resident could start falling and you can't catch them and they could get injured. Before (R3's) fall I think she was a 1 assist for transfers and now she is a mechanical lift with 2 staff assist." On 6/24/21 at 8:34AM, V9 (Restorative Nurse) stated, "Gait belts should be used for all 1 person assist transfers. They should be used for patient safety so that if a resident begins to fall the staff can either prevent the fall or assist them to the floor to hopefully prevent injury. The restorative assessment shows what assistance a resident requires and residents transfer status should not change unless they are evaluated by restorative or physical therapy first." (A)	S9999		