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
	IL6011910	A. BUILDING: _____ B. WING _____	C 04/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST PATRICK'S RESIDENCE	1400 BROOKDALE ROAD NAPERVILLE, IL 60563

(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
S 000	Initial Comments Investigation of Facility Reported Incident of April 13, 2022/ IL146119	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b)4)5) 300.1210 c) 300.1210 d)6) 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 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.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to safely transfer a resident per the facility's policy and the resident care plan. As a result of this failure, R1 sustained a laceration to R1's head during a	S9999		

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S9999	Continued From page 2	S9999		

transfer. R1 was transferred to local hospital and received 3 staples to the back of R1's head. This applies to 1 of 3 residents (R1) reviewed for transfers.

Findings include:

On 4/26/22 at 11:24 AM, R1 was observed in her room sitting up in bed resting. R1 said after getting a shower, staff was attempting to transfer back to her bed, she fell from the mechanical lift. R1 said she does know what happened, "something gave in", and she fell and hit her head. R1 said she was sent to the hospital and had three staples to the back of her head. R1 said there was only one staff with her during the transfer. R1 said she would prefer if there were two staff with mechanical lift transfers.

R1's face sheet shows the following diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting right dominant size, spinal stenosis lumbosacral region, abnormalities of gait and mobility and need for assistance with personal care. R1's MDS (Minimum Data Set) dated 2/8/22 shows R1's cognition is intact and R1 is total dependence with two or more staff assist with transfers. R1's care plan initiated on 8/13/21 and revised on 2/8/22 shows R1 requires a mechanical lift and two persons for transfers.

The facility's incident report dated 4/19/2022 shows "Resident sustained a laceration to the back of her head during a failed transfer using a mechanical lift. CNA (Certified Nurse Aide) notified nurse that resident was on the floor, he stated he was transferring the resident from the shower chair to her bed when she slipped through the opening in the sling to the floor. Sling was not properly positioned on the resident and

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S9999	Continued From page 3 was too large. 911 was called and resident was transported to hospital for treatment and evaluation. Resident received three staples to the back of her head. Resident returned to facility later that evening." According to V8 CNA witness statement states "After the shower I put the sling back on her ready to put her to bed. After lifting her about two feet up and all of a sudden resident came out the hole from the sling. I thought the sling was oversized and I reported to my nurse." On 4/26/22 at 2:47 PM, V8 (CNA) said on the day of the fall, after giving R1 a shower, he took R1 back to her room. V8 said he had R1 lean forward in the shower chair and then slid the sling behind her back and then he crossed the straps of the sling under R1's legs and hooked the straps straight up to the bar of the mechanical lift. V8 said after he hooked the straps, he raised the lift, and R1 was suspended in the air and R1 fell through the hole. V8 said R1 fell back and hit the back of head on the leg of the mechanical lift. V8 stated that he was the only staff member in the room during R1's transfer. V8 said he did R1's transfer on his own before and after R1's shower. V8 said after R1 fell he told V3 (Registered Nurse/RN) he dropped R1 on the floor and the ambulance was called. V8 stated he did know he wasn't supposed to do mechanical lift transfers by himself. V8 stated he did not check the size of R1's sling prior to the transfer, but he thinks the hole in the sling where R1's butt went was too big. On 4/26/22 at 11:43 AM, V3 (RN) said on the day of the fall, V8 (CNA) informed her that R1 fell. V3 said when she got to R1's room, she observed her lying on the floor. V3 said there was blood on the floor and R1 said "he dropped me". V3 said she did R1's vitals and called 911. V3 said V8 was alone with R1 during the mechanical lift	S9999		

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S9999	Continued From page 4 transfer. V3 said V8 should have called her before putting R1 in sling to make sure it's the right sling. V3 said it always takes two people to help with transfers. On 4/27/22 at 11:35 AM, V11 (RN) via phone interview said R1 came back from the ER (Emergency Room) and had three staples on the back of her head. On 4/27/22 at 9:14 AM, V6 (Physical Therapist/PT) said since admission, R1 has always required a mechanical lift for transfers. V6 said physical therapy assess and makes recommendation on transfer techniques for residents. V6 said there should always be two staff during mechanical lift transfer for safety reasons. On 4/27/22 at 11:58 AM, V1 (Administrator) said R1 injured her head during a mechanical lift transfer by V8 (CNA.) V1 said R1 was sent to the ER after the fall. V1 said it requires two staff for mechanical lift transfers. On 4/27/22 at 9:45 AM, V7 (R1's Physician) via phone said, he is aware that R1 went to the emergency room after the fall. V7 said per facility policy, there should always be two staff members with mechanical lift transfers. There was only one staff member when R1 was transferred. V7 said per facility protocol, residents should be assessed by PT for safe transfers, and recommendations should be followed. According to R1's hospital record dated 4/13/22 shows R1 had posterior head laceration and had three staples to the laceration. The facility's policy titled Mechanical Lifts/(Brand	S9999		

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S9999	Continued From page 5 name lift) (October 2015), under Guidelines: "3. For safe operation of the (Brand name lift), always have two people to lift resident. Under Procedure: "1. Review the resident's plan of care and/or the resident's care guide. 3. For safety, make sure that two people are performing this procedure." "B"	S9999		