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
	IL6006027	A. BUILDING: ______ B. WING ______	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE VILLAGE HEALTHCARE CTR	1024 WEST WALNUT JACKSONVILLE, IL 62650

(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 Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.610c)4) 300.1210b) 300.1210d)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 300.610 Resident Care Policies c)The written policies shall include, at a minimum the following provisions: 4) A policy to identify, assess, and develop strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a resident. Section 300.1210 General Requirements for Nursing and Personal Care b)The facility shall provide the necessary care	S9999	**Attachment A** **Statement of Licensure Violations**	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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S9999	Continued From page 1 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. Section 300.1210 General Requirements for Nursing and Personal Care 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. Based on observation, interview and record review, the facility failed to provide supervision to prevent falls, investigate falls thoroughly to determine a root cause analysis and implement progressive interventions to prevent falls, provide safe transfers, and ensure transfer equipment is in good condition for 5 of 8 residents (R9, R10, R14, R17, R27) reviewed for falls and transfers in the sample of 31. This failure resulted in R17 falling 5 times,sustaining bumps to the back of her head, and another fall resulting in R17 going to the Emergency Room and receiving 8 staples to the back of her head. Finding include:	S9999		

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1.R17's Face Sheet, undated, documents R17 was admitted on 9/22/20 and has diagnoses of cerebral infarction, dementia with behavioral disturbance, anxiety, personal history of (healed) traumatic fracture of right tibia and left femur.

R17's Minimum Data Set (MDS), dated 10/19/21, documents R17 is severely cognitively intact, has inattention and disorganized thinking that fluctuates and changes in severity, requires extensive assistance of 1 staff member for bed mobility, walking in room and hallway, locomotion on unit, not steady only able to stabilize with staff assistance for moving from seated to standing position, walking, turning around, and surface to surface transfer.

R17's Safety Events - Fall Event Full Body and Pain report, dated 1/11/22 at 7:09 PM, documents, "Description: Resident walked across hall and fell on her buttocks in someone else's room." This report documented that prior to this fall R17 was walking in her room. The report documented this fall was witnessed. The report documented "She walked into room bumped into the bedside table, lost balance and fell in a spin, landing on her buttocks and hitting her head on floor." The report documented that R17 was calm and confused and usually required of assistance of one when walking. The report documented "Initial Observation or complaint of injury: Right side / back pain, no bruising, skin tears, or other injuries noticeable. Observation of skin on trunk / torso / lower body: C/O (complaint of) tenderness. Physical symptoms: Resisting certain movements. Description of Pain: Back pain. Other: Right side pain. Medical Care provided after fall: Transferred to ER for evaluation."

R17's Occurrence Report, dated 1/11/22,

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S9999	Continued From page 3 documents, "Nurse Note of what happened: Her alarm sounding went to investigate and observed resident sitting on her buttocks in room across hallway from resident's room. Witness Statement: (R62) stated, "she walked in my room and the next thing I know is she was on the floor." The Report documented R17 was barefoot and an alarm sounded. The Report Conclusion documented "Resident stood from her w/c (wheelchair) in her room and ambulated across the hallway into another resident's room, lost her balance and landed on her buttocks." The Report documented the Root cause as "Due to resident action or internal risk factors." The Report Recommendation documented "toilet every hour." R17's Nurse's Note, dated, 1/11/22, documents, "Resident fell in room across the hall from hers at (7:00 PM) and was found in the sitting position at (7:05 PM). She is c/o (complaining of) Right side and back pain. Unable to take a deep breath and is desatting without oxygen on. VS (vital signs): 97.8 (temperatures), 78 (pulse), 14 (respirations), 140/78 (blood pressure), 90-93% (oxygen saturation level). Writer is going to send her to the ER (Emergency Room) for eval (evaluation)." R17's MDS, dated 1/12/22, documents R17 is moderately impaired, has inattention and disorganized thinking that fluctuates and changes in severity, requires extensive assistance from 2 staff members for bed mobility, transfers, locomotion did not occur and requires extensive assist from 1 staff member for eating. This MDS also documents R17 is not steady and only able to stabilize with staff assistance for moving to seated to standing, walking, surface to surface transfer and uses a wheelchair for mobility. The facility failed to provide a Care Plan for R17	S9999		

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S9999	Continued From page 4 that was before 1/13/22. R17's Care Plan, dated 1/13/22, document, "(R17) is at risk for falls with injury visual impairment, on psychoactive and cardiac medication, and recent fall in the room with injury on 1/11/22." The Care Plan Interventions dated 1/17/22 documented "When (R17) is up in her w/c (wheelchair) she is to be under supervision of staff and in a populated area. When (R17) is fidgety and won't stay seating take her for a walk using gait belt. Provide toileting assistance at least every hour, as needed, or when she becomes restless. Provide proper well-maintained footwear. Provide (R17) an environment free of clutter. Pressure alarm to (R17's) bed and wheelchair. Occupy (R17) with meaningful distractions: music, one on ones, crafts, laundry to fold, etc. Non-skid to w/c seat. Non skid socks on when up to wheelchair. (R17) is to use HI/LO bed for safety. (R17) is not to be left in dining room unattended. Give (R17) verbal reminders not to ambulate/transfer without assistance. Encourage (R17) to wear her eyeglasses and that her eye glasses are clean and in good repair. Do not leave in bathroom unattended. Assure (R17) is wearing non skid socks at all times, including while in bed. Assure brakes are always locked on wheelchair when not being used for locomotion." R17's Safety Events - Fall Event Full Body and Pain report, dated 2/8/22 at 6:28 PM, documents an unwitnessed fall. The Report documents "Resident fell to the floor in dining room." The Report documented R17 was drinking coffee prior to the fall. The Report documents "Resident fell forward after standing up on own and landed under a dining room table." The Report documents that R17 was in her wheelchair prior	S9999		

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to the fall. The Report documented "Resident stated she has a headache. Observation of skin on head / neck: Redness, swelling, c/o tenderness. If any describe including size, color, exact location: 4 cm (centimeters) x 4 cm bump in the middle of the back of head, then down approximately 4.5 cm is a 2.5.cm x 2.5 cm bump. She also had a 2.5 x 3 red area to the right forehead just above the eyebrow. Description of pain: Headache. Medical care provided after fall: Basic first aid. Interventions and immediate Measures taken: analgesics, cold application. Evaluation: no documentation."

R17's Occurrence Report, dated 2/8/22 at 6:40 PM, documents, "Nurse's Note of what happened: (V24. Licensed Practical Nurse) called to dining room by (V11) Licensed Practical Nurse (LPN) notified of resident observed on floor under dining room table." The Occurrence Report documents a Witness Statement of what happened as "(R14) in dining room at time of incident stated, "she was sitting in her w/c (wheelchair) with her head lying on the table asleep, next thing I knew she was at another table on the floor. I did not actually see it happen, I think she got up from her w/c and walked over to the other dining room table and fell." The Report documented R17's alarm was sounding. The Report documented Conclusion "(R17) was upright in her w/c in dining room with her head laying on dining room table asleep, according to interviewable resident in dining room at the time of incident. Interviewable resident stated that she did not see her fall just happened to look up and resident was on the floor at a different table and that w/c was still in place at the table where she was last seen by this resident. Resident arose from her w/c, ambulated to another table without assistive device which caused her to land on the

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floor. Root cause: Due to resident action or internal risk factors." This Report did not document that staff were present in the dining room at the time of the incident and supervising R17.

R17's Fall Care Plan Intervention, dated 2/9/22, documented "(R17) is to be the last one in the dining room and the first out of the dining room."

R17's Safety Events - Fall Event Full Body and Pain report, dated 2/10/22 at 3:33 PM, documents, " Resident fell to the floor in resident's room." The Report documented that R17 was in her bed prior to the fall and the fall was not witnessed. The report documented "Resident 'walking around in the kitchen' bumped into dresser and pulled TV off and on top of her." The Report documented "Observation of skin on head / neck: Skin tear / laceration. If any describe including size, color, exact location: 3 cm (centimeter) x (by) 2 cm laceration to the back left side of head. Objective symptoms: Nonverbal sounds of distress such as crying, groaning, moaning, whimpering, whining. Medical care provided after fall: Transferred to ER for evaluation. Interventions and immediate measures taken: cold application, direct pressure to wound." The Report documented "Evaluation: Her room was moved closer to the nurse's station to be closely monitored."

R17's Facility Report Form, dated 2/16/22, documents, "Reportable Event Occurred On: 2/10/22 at 3:20 PM. Description of Occurrence: Alleged resident fall resulting in a laceration to posterior left side of her head. M.D. (Medical Doctor) examined at the time with orders to transfer to (local hospital) for evaluation / treatment." This investigation fails to document a

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root cause.

R17's Nurse's Noted, dated 2/10/22, documents, "At 3:20 PM Res (resident) heard by Maintenance yelling for assistance, noted sitting on floor of room, with TV on floor, stated 'I was walking to kitchen' fell into dresser knocking it over and tv fell on top. Res was laying on roommates' side of room, No witnesses, VS: T:98.0, P:78, R:16, B/P:106/70, SPO2 (oxygen level): 97% RA (room air), has open area to back of head, (V29 Doctor) here at facility, checked Res. ordered to send res to (local hospital) to eval (evaluation) and tx (treatment)." The Nurse's Note did not document her bed alarm was sounding at the time she was found.

R17's Nurse's Note, dated 2/10/22, documents, "Res returned from ER, Had CT (Computed Tomography) of cervical spine, Head, area to back of head closed w (with)/staples."

R17's Nurse's Note, dated 2/11/22, documents, "WEEKLY SKIN NOTE: Resident continues with 8 staples to back of head. No s/s (signs and symptoms) of infection. No complaints of pain."

R17's Fall Care Plan Intervention for Falls, dated 2/11/22, documented "(R17) moved closer to nurse's station and Anti-tippers to w/c."

R17's MDS, dated 4/12/22, documents R17 is moderately impaired, has inattention and disorganized thinking that fluctuates and changes in severity, requires extensive assistance from 2 staff members for bed mobility, transfers and requires extensive assist from 1 staff member for locomotion and eating. This MDS also documents R17 is not steady and only able to stabilize with staff assistance for moving to seated to standing,

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walking, surface to surface transfer and uses a wheelchair for mobility.

R17's Safety Events - Fall Event Full Body and Pain report, dated 5/1/22 at 10:41 AM, documents, "Description: Fall to floor. Location of fall: Dining Room. What was the resident doing just prior to fall? Sleeping. Was fall witnessed? Yes. Detailed description of fall: Fell right against wall and slid down wall hitting the floor. What was the resident's location prior to fall? In bed. Mental status prior to fall: confused, sleepy. Resident's usual ambulatory status: assist of one with / without device. Describe, if necessary: Resident tends to get up on own and ambulate very unsteady. Initial observation or complaint of injury: No injuries and no c/o pain at this time. Evaluation: Drinks to be placed in front of (R17) prior to leaving her at the table."

R17's Occurrence Report, dated 5/1/22 at 6:52 AM, documents, "Conclusion: (R17) was sitting in the dining room at her table waiting for staff to get her a drink. Staff turned around to go get the drink and (R17) got up without assistance to attempt to get it herself. Root cause: Due to cognition (R17) attempted to get her own coffee instead of waiting for staff."

R17's Nurse's Note, dated 5/1/22, documents, "At 6:52 AM this morning this nurse was called to the dining room where resident had fallen to the floor. There were no injuries noted and neuro checks were initiated. Staff got (R17) up out of bed for breakfast, brought her into the dining room and placed her at the table. Staff left her side to go get her some coffee that she was requesting. D/t (due to) her cognitive status and short-term attention span, (R17) was attempting to stand up to go get her own coffee when she fell to the right

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S9999	Continued From page 9 against the wall and slid down to the floor. A full body assessment was completed and no injuries were noted. Another resident was in the dining room at the time and stated that (R17) had hit her head against the wall, so neuro checks were initiated. The resident needs to have her water and coffee at the table before she arrives to the table so that in the future this can possibly be prevented." R17's Fall Care Plan Fall Intervention, dated 5/1/22 documents "Drinks to be placed in front of (R17) prior to leaving her at table." R17's Safety Events - Fall Event Full Body and Pain report, dated 5/10/22 7:06 PM, documents, " Description: Fall. Location of fall: Hallway. What was resident doing just prior to fall? sitting in chair. Was the fall witnessed? Yes. Description of fall: resident lowered self to back. What was resident's location prior to fall? in wheelchair. Mental status prior to fall: calm, confused. Residents' usual ambulatory status: assist of one with / without device. Initial observation or complaint of injury: No injuries. Evaluation: N/A event still open." R17's Occurrence Report, dated 5/10/22, documents, "Nurses note of what happened: Resident was standing unassisted and lowered self to floor. Witness statement of what happened: Resident stood up, told her to sit down, then resident lowered herself to floor. Alarm: None. Conclusion: (R17) is at risk for falls with injury visual impairment, on psychoactive and cardiac medication. Root cause: Due to resident action or internal risk factors." This Report documented that no alarm was in place. R17's Nurse's Note, dated 5/10/22, documents,	S9999		

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"Resident had witnessed fall in corridor, no injuries noted, ROM intact, resident remains confused per baseline, resident did not hit head, Resident stated she was standing because she was waiting for a kiss, and then laid down, no c/o pain. VS 97.2, 68, 18, 126/58, 97% RA."

R17's Fall Care Plan Intervention, dated 5/10/22, documented "When (R17) rises from her w/c without assistance and staff are near a gait belt is to be immediately placed on her person."

On 6/15/22 at 10:02 AM, V11 LPN, stated, "She (R17) doesn't know her limits. She likes to get up. She was in the dining room screaming for coffee. The aide (does not remember who) got up and went to get her coffee to make her stop screaming. The next thing you know she is under the table. When she gets impulsive with me, I keep her within arm's reach. In my opinion the aide should not have left her but I think she was just trying to make her stop screaming."

On 6/13/22 at 12:38 PM, V8 CNA, stated, "She (R17) is constantly up and down. She is a high fall risk. We have an alarm on her, we try to redirect her, walk her around and she gets cold so we put lots of blankets and her and that seems to help."

On 6/16/22 at 8:00 AM, V1, Administrator, stated, "She (R17) is hard." When questioned if R17 should have been left alone at the table while she was screaming for coffee as impulsive as she is, V1 stated, "I am going to have to review the notes. I am not sure. V1 stated, "I was here the day she got the laceration. (V29, Physician) was in the building. We had (V29) evaluate her and he gave us orders to take her to ER. We got the bleeding to stop. We applied ice. (R17) was

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S9999	Continued From page 11 awake and alert. I and the van driver drove her to the hospital and stayed with her until her Power of Attorney arrived." On 6/16/22 at 12:15 PM, V1stated, "She (R17) should have footwear on but she does take her socks off. She really needs a one on one which we don't have the staff for. I am not giving that as answer though. The last fall she was sitting next to the nurse. She is very impulsive." 2. R14's MDS, dated 4/5/22, documents R14 is totally dependent of 2 staff members for transfers. R14's Care Plan, dated 1/11/22, documents, "(R14) is at risk for falls due to quadriplegia. (R14) uses assist of 2 staff (mechanical) lift for transfers." On 06/13/22 at 1:16 PM, V13 CNA was standing behind R14's wheelchair. V8, CNA was operating the controls while pushing the full body mechanical lift. R14 was swinging in the air. V13 and V8 were transferring R14 using a white sling. There was signage on the wall documenting R14 should use a blue sling only. On 6/14/22 at 12:58 PM, V13 and V12, CNA, entered R14's room to transfer R14 to bed with a mechanical lift. R14 was sitting on a white mechanical lift sling. V12 and V13 attached the sling to the lift. V12 raised the lift while V13 stood behind the wheelchair. While R14 was being raised it was observed that the sling had a hole in the back of the sling the approximate size of an orange. V12 pushed R14 over to the bed. V13 stood on the right side of the bed. V13 at no time held the sling while R14 was being pushed over to the bed.	S9999		

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(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 12 On 6/14/22 at 1:10 PM, V12 was questioned about the signage on R14's wall documenting, "Use Blue sling only". V12 stated, "We are supposed to use a blue sling on her but she threw up on it last night and I had to send it to laundry." V12 stated, "The difference between the blue and white slings is the blue is a full body sling and it is wider so it doesn't push her so much." V12 also stated that she was unaware of the hole in the white sling and that the aides are supposed to check the straps for rips or threads. On 6/15/22 at 12:00 PM, V1, Administrator, stated, "The laundry aides should look at all the slings and inspect them. They should have noticed the hole in that sling that should not have happened." 3. R9's Care Plan, dated 1/11/2022, documents "(R9) is limited in ability to transfer self R/T (related to) unsteadiness on feet, generalized muscle weakness, and hx (history) of falls. (R9) has diagnoses of hx of displaced intertrochanteric fracture of left femur, diabetes mellitus due to underlying condition with diabetic nephropathy, unspecified systolic (congestive) heart failure, other persistent atrial fibrillation, chronic lymphocytic leukemia of B-cell type in remission, chronic kidney disease, stage 4 (severe), hypothyroidism, unspecified, iron deficiency anemia, unspecified, other insomnia, other specified depressive episodes, gastro-esophageal reflux disease without esophagitis, restless legs syndrome, primary pulmonary hypertension, hyperlipidemia, unspecified. (R9) needs ADL assistance. (R9) is alert and oriented times three with some confusion." The Care Plan documents (R9)	S9999		

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	IL6006027	A. BUILDING: ______ B. WING ______	06/16/2022

NAME OF PROVIDER OR SUPPLIER: PRAIRIE VILLAGE HEALTHCARE CTR

STREET ADDRESS, CITY, STATE, ZIP CODE: 1024 WEST WALNUT, JACKSONVILLE, IL 62650

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requires limited to extensive assistance of one to two staff for transferring and toileting. The Care Plan documents "The amount of assistance required may fluctuate throughout the day. Provide the amount of assistance required and document every shift, daily."

R9's MDS, dated 4/6/2022, documents extensive assist of 2 staff for transfers.

On 6/13/2022 at 10:30 AM V7, CNA transferred R9 on and off the toilet without the use of a gait belt. V7 grabbed R9 by the arm and assisted her into the standing position pulled up R9's pants and then grabbing hold of R9's pants transferred her into the wheelchair.

The facility's Gait Belts policy, dated 4/13, documents "General: Gait belts are used to help prevent injury of staff or residents during transfers and ambulation. Policy: Gait belts should be used by all staff when ambulating or transferring a resident with an unsteady gait. 9. To transfer the resident, assist to standing by holding the belt at the waist and pivot the resident to the chair. 10. To ambulate the resident, stand at the resident's weak side and grasp the belt at the waist underneath."

4. R10's Care Plan, dated 5/27/2022, documents "(R10) is at risk for falling R/T CVA (stroke) causing right sided weakness." The Care Plan documents "Assist (R10) to assume a standing position slowly." R10's Care Plan Intervention, dated 4/16/22, documents "Alarming floor mat on floor beside bed." R10's Care Plan Intervention, dated 11/11/21 documents "Pressure alarm to w/c (wheelchair). R10's Care Plan Intervention, dated 12/2/21, documents "Pressure alarm in bed also."

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R10's MDS, dated 4/5/2022, documents R10 requires extensive assist of 2 staff for transfers.

On 6/13/2022 at 12:10 PM V8 and V7 transferred R10 to the toilet without a gait belt. R10 was sitting on the toilet with no gait belt on. At 12:18 PM R10 stated that she was finished. V8 stated that R10 had to wait until they got a gait belt. At 12:20 PM R10 stated that she has never worn a gait belt and no one has asked her to wear one. At 12:22 PM V8 assisted R10 into a standing position and assisted with cleansing. V7, alone, ambulated R10 from the bathroom to the bed. R10 had an unsteady balance when ambulating.

On 6/13/2022 at 12:23 PM, V8 stated that she did not use a gait belt when transferring R10 to the toilet. V8 stated that she had R10 hold on to the bar and helped her stand and sit on the toilet. V8 stated that they are to use a gait belt when transferring R10 but she did not have one on her.

On 6/14/2022 at 12:12 PM, R10 was ambulating in room and no alarm was sounding. At 12:13 PM., R10 was standing at bathroom door with V27, CNA, no alarm sounding. V27 requested a gait belt. V27 then ambulated R10 from the bathroom to the bed, no gait belt applied. There was an alarm pad on the floor, partially beneath the bed and alarm box unattached. Once in the bed V27 then removed the alarm box from the wheelchair cross the room and attached it to the alarm pad.

On 6/14/2022 at V27 stated that she was passing the room and saw R10 coming from the bathroom. V27 stated that R10 is a high fall risk and that she requires monitoring.

On 6/16/2022 at 12:10 PM V11, LPN, stated that

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she would expect the staff to use a gait belt when manually transferring a resident.

5. R27's Care Plan, last review dated 4/20/2022, documents "Problem: (R27) is at risk for falling R/T weakness." It continues "Approach: assist (R27) to assume a standing position slowly using the sit to stand and two staff." It also documents "Problem: (R27) is a 76-year-old Caucasian male that admitted to facility from outlying hospital where he was being treated for generalized weakness, small bilateral pleural effusion, stercoral colitis, small to moderate pericardial effusion, CKD (Chronic Kidney Disease) stage 3, hyperlipidemia, and UTI (Urinary Tract Infection). (R27) is alert and able to make his needs known."

On 6/13/20222 at 12:40 PM V9, CNA and V10, CNA, assisted R27 with a transfer from the wheelchair to the recliner. V9 and V10 applied the gait belt to R27 and lifted R27 into a standing position with knees bent. V9 and V10 then turned R27 and pulled him over in front of the recliner, dragging R27's feet. V9 and V10 then sat R27 into the recliner. R27 did not participate in the transfer.

On 6/13/2022 at 10:15 AM R27 stated that he needs help with getting into his chair. R27 stated that sometimes the staff transfer him themselves and sometimes they use the lift. R27 stated that it depends on who is here. R27 stated that he is supposed to use the standup lift.

On 6/13/2022 at 12:30 PM V7, CNA, stated that someone was going to assist R27 into the bed they were trying to find the mechanical lift.

On 6/16/2022 at 12:10 PM V11, LPN, stated that R27 requires the standup (partial) mechanical lift

Illinois Department of Public Health

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S9999	Continued From page 16 to transfer and would expect the staff to transfer R27 with the standup mechanical lift. On 6/16/2022 at 10:00 AM V20, Restorative Nurse, stated that she had a list of how residents are transferred. V20 stated that R27 did require a partial mechanical lift but now requires a 2-person manual transfer. V20 stated that R27 is receiving therapy and therapy changed his transfer. V20 stated that if R27 is not bearing weight and not participating in the transfer than he would need a mechanical lift. On 6/16/2022 at 10:15 AM V18, Therapy Director, stated that R27 is being seen by therapy. V18 stated that per the documentation therapy is working on transfers with R27. V18 stated that R27 was requiring max assist with verbal cues for therapy. V18 stated that R27 had increased leaning back with transfers and when standing still. V18 stated that if you didn't have hold of him, he would fall. V18 stated that R27 had decrease lateral stepping movement for pivoting cause R27 not to move feet with transfer. R27 stated that when transferring the resident therapy is performing the manual transfer. V18 stated this is not the transfer that nursing is doing. V18 stated that they would not tell nursing to perform an unsafe transfer. V18 stated that although it may look good in therapy notes it is actually saying he is having a decline. When notified of the care plan documenting partial mechanical lift, V18 stated that this would be the correct transfer. V18 stated that therapy would not change the residents transfer unless they are sure it would be safe. V18 stated that as current decline they are not at a point where they would change R27's transfer from a partial mechanical lift to a 2-person manual transfer.	S9999		

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S9999	Continued From page 17 On 6/16/2022 the Facility Transfer policy was requested. The facility did not provide a policy. The policy "Falls", dated 8/2008, documents, "5. The staff will evaluate and document falls that occur while the individual is in the facility, for example, when and where they happen, any observations of the events, etc. 1. For an individual who has fallen, staff will attempt to define possible causes within 24 hours of the fall. 2. If the cause of a fall is unclear, if the fall may have a significant medical cause such as a stroke or an adverse drug reaction, or if the vindictive continues to fall despite attempted interventions, a physician will review the situation and help identify contributing causes. a. After more than one fall, the physician should review the resident's gait, balance, and current medications that may be associated with dizziness or falling. 3. The staff and physician will continue to collect and evaluate information until either the cause of the falling is identified, or it is determined that the cause cannot be found or that finding a cause would not change the course or the management of falling and fall risk. Treatment Management: 1. Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls ant to address risks of serious consequences of falling. 2. If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions, based on assessment of the nature or category of falling, until falling reduces or stops or until a reason is identified for its continuations (for example if a resident continues to try and get up and walk without waiting for assistance.)" (B)	S9999		