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 07/06/2022

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

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S 000	Initial Comments Facility Reported Incident of 6/25/22/ IL148533	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 well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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) These Regulations were not met as evidenced by: Based on observation, interview, and record review the facility failure to ensure residents were	S9999		

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S9999	Continued From page 2 safely transferred with a mechanical lift for 2 of 3 residents (R1, R3) reviewed for safety. These failures resulted in R1 sliding from the mechanical lift and sustaining a subdural hematoma (brain bleed); left temporal hematoma with a skull fracture; left clavicle fracture; and left humerus fracture. R1 is currently hospitalized and was transitioned to hospice care. Findings include: 1. The facility's Final Incident Report dated 6/28/22 showed that R1 was being transferred by Certified Nursing Assistant (V11) from the bed to the chair when R1 slipped from the lift sling and onto the floor. R1 hit her feet first then hit her head on the floor. R1 was assessed by the nurse and was bleeding from her head. R1 was sent to the emergency department via 911. The hospital reported R1 was admitted with an intracranial hemorrhage (brain bleed). R1's Face Sheet dated 7/5/22 showed R1 had diagnoses to include, but not limited to heart failure, previous heart attack, hypothyroidism, dementia, left hand contracture, emphysema, severe protein-calorie malnutrition, generalized muscle weakness, dysphagia, weakness, reduced mobility, presence of a gastrostomy tube (G-tube, feeding tube inserted directly into stomach), cystitis, nutritional deficiency, age related osteoporosis, and Alzheimer's disease. R1's facility assessment dated 5/26/22 showed R1 had severe cognitive impairment and was dependent on two staff members for bed mobility, transfers, and toilet use. R1's ADL (Activities of Daily Living - ADLs) Care Plan revised 2/15/22 showed R1 required	S9999		

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S9999	Continued From page 3 assistance with ADLs related to Alzheimer's Disease, ataxic gait, dementia, weakness, left hand contracture, and reduced mobility. This care plan showed R1 required a mechanical lift for all transfers, with a two person assist. R1's Fall Event dated 6/25/22 at 11:50 AM, showed R1 slid from the mechanical lift during a transfer. This document showed R1 was alert, her pupils were equal and reactive, she was non-verbal (resident's baseline), and had pain to the left lower extremity when it was touched. R1's Progress Note dated 6/25/22 at 12:25 PM, showed, "CNA assigned to the patient told me to go and check the patient who fell during [mechanical lift] transfer. Noted patient lying down with blood underneath her head." The nurse called 911, V7 (R1's Power of Attorney - POA) and supervisor. R1 was transferred to the local hospital via ambulance. On 7/5/22 at 12:13 PM, V11 (CNA) said she had been working at the facility a little over a month. V11 said she was assigned to R1 on 6/25/22 (the day of the incident). V11 said she was passing the noon meal trays and knew that R1 required feeding assistance. R1 is dependent on us for all her care. I got her dressed, provided incontinence care, and placed the sling under her. I was trained with the slings that have four straps, but that one, that had six straps. I don't know why I didn't ask for help. It was lunch time, and we were all busy. I should have had someone else in the room with me. We are supposed to have two staff for all lift transfers, but I tried to do the transfer myself. R1's sling had longer legs and was shaped a little differently. I guess I was supposed to crisscross the lower (leg) straps, between her legs to hold her in place, but I didn't. I just	S9999		

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S9999	Continued From page 4 attached them to the bar like I do with the normal straps. I had R1 in the air, above her wheelchair and I was having trouble. The base of the lift was opened around R1's wheelchair and I was positioned behind the wheelchair. I moved the lift and R1's left foot bumped the arm rest on the wheelchair, and she swayed in the air. When she swayed to the side, she slid out of the sling. Her feet landed first, then she hit her head. She landed on her left side. It happened so fast that I couldn't get to her fast enough to stop her from hitting her head. R1 wasn't yelling in pain and she didn't lose consciousness, but I noticed her head was bleeding on the left side, above her ear. I tried yelling for help, but everyone was busy. I ran in the hall to V10 (R1's RN) and told her I needed help, then I went back to R1. The nurses (V9 and V10, RNs) checked R1 and called the ambulance. After they assessed her, I put a pillow under her head and put light pressure on the left side of her head, where she was bleeding. R1 went to the hospital. I'm not sure what happened after that. I received more lift training and was suspended. I haven't worked at the facility since the incident. On 7/5/22 at 11:27 AM, V10 (RN) said she was working the day R1 fell from the mechanical lift. V10 said she was in the hall, passing medications. V10 said V11 ran down the hall and said she needed help that R1 had fallen during a mechanical lift transfer. She said when she went in the room R1 was lying on her left side, on the floor. I saw blood on the floor and I wasn't sure of the extent of the injury. I did an assessment, then went to call the ambulance. She had blood coming from the left side of her head, so I had V11 put a small pillow under her head and put light pressure on her head. V10 said R1 was non-verbal most of the time but would smile	S9999		

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S9999	Continued From page 5	S9999		

occasionally. V10 said R1 was so skinny and stiff. When I touched her left leg, R1 screamed. I knew something was wrong. V10 said V9 (RN) helped me to get the vital signs. V10 said R1 was sent to the hospital and had not returned to the facility. V10 said V11 (CNA) had been on R1's assignment for about a week and had not reported any concerns with using the mechanical lift or the sling. V10 said we all get training on the lifts when we get hired and at least once a year.

On 7/5/22 between 9:00 AM and 4:00 PM, V9 (Licensed Practical Nurse - LPN), V10 (RN) and V12-V16 (CNAs) said they were working on 6/25/22 and none of them assisted V11 with R1's mechanical lift transfer. They all said there should always be two staff members during a mechanical lift transfer for resident safety.

On 7/5/22 at 1:52 PM, V2 (Director of Nursing) said V2 said R1 was dependent on staff for all care. R1 was immobile, stiff, and small in stature. R1 slid from the mechanical lift because V11 didn't follow the facility's mechanical lift policy. V2 said V11 was performing the lift alone and had placed the sling on the lift improperly. V2 stated, "There should always be two staff when they perform a mechanical lift transfer for resident safety." V2 said if any staff member is unsure about something, they should ask for help. V2 stated, "It's very unfortunate, but that's why she (V11) was provided 1:1 counseling/training and suspended from work." V2 said V11 had not worked since the incident occurred.

On 7/5/22 at 1:41 PM, V8 (Hospital RN) said she was caring for R1 at the hospital. V8 said R1 fell from a mechanical lift and underwent a full workup. V8 said R1 had subdural hematoma (brain bleed); left temporal hematoma with a skull

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S9999	Continued From page 6	S9999		

fracture; left clavicle fracture; and left humerus fracture. V8 said R1 did not have any surgical intervention and was placed on hospice care on 6/29/22. V8 said R1 was receiving intravenous pain medication.

On 7/5/22 at 2:34 PM, V3 (R1's Physician) said R1's health had been slowly declining due to her dementia. R1 was non-ambulatory, not eating, had a G-tube for nutrition, nonverbal, and not interactive. V3 said R1 had an extended hospitalization earlier in the year and was slowing declining since. V3 was notified of R1's subdural hematoma (brain bleed); left temporal hematoma with a skull fracture; left clavicle fracture; and left humerus fracture. V3 said the fall from the mechanical lift definitely could have caused these injuries.

V11's Employee Disciplinary Report dated 6/25/22 showed V11 was suspended immediately for "Failure to follow facility policies on using (a mechanical lift) transfer safely."

The facility's undated Safe Patient Lifting Policy showed, "Purpose: The Safe Patient Lifting Policy exists to ensure a safe working environment for resident handlers... Total Lift Transfer with 2 or more caregivers (Total Assist)... This policy will be included in orientation and direct staff will not be allowed to transfer residents until they have completed the transfer competency..."

2. On 7/5/22 at 9:30 AM, V12 (Certified Nursing Assistant - CNA) and V13 (CNA/Restorative Aide) transferred R3 from the bed to his wheelchair using a mechanical lift. R3 was well-groomed, sitting in his wheelchair after the transfer. R3 had a liner skin tear to his left, lateral elbow (antecubital) area. The skin tear was scabbed

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S9999	Continued From page 7 with two steri strips intact. R3 said he didn't know how he got the skin tear. R3's Fall Event dated 6/7/22 showed R3 sustained a skin tear to his left elbow. This document showed R3 was sling broke while transferred. R3's Progress Noted dated 6/7/22 showed, "Patient transferred by CNA using mechanical lift. Sling broke. Patient fell slowly to floor with CNA. Did not hit head..." R3's Nurse Practitioner Noted dated 6/8/22 showed R3 was evaluated for follow-up with chronic conditions and the nurse reported R3 had a witnessed fall on 6/7/22. This document showed resident denied hitting his head. The only injury was a skin tear. The nurse reported while R3 was being transferred with a mechanical lift and the sling broke as R3 was being lowered to the wheelchair. R3's Face Sheet dated 6/5/22 showed diagnoses to include, but not limited to: prostate cancer, chronic kidney disease, lymphedema, diabetes, history of falling, obesity, arthritis, and chronic heart failure. R3's facility assessment dated 6/13/22 showed R3 had moderate cognitive impairment and was dependent of two or more staff for transfers. R3's Care Plan for transfers revised 6/15/21 showed, "R3 exhibits decreased ability to transfer self from wheelchair to chair/bed due to decreased functional mobility and generalized weakness. Requires (total) mechanical lift with 2 person assist."	S9999		

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S9999	Continued From page 8 On 7/5/22 at 2:12 PM, V18 (Licensed Practical Nurse - LPN) said he was working on 6/7/22. I was charting at the desk when V17 (CNA) came and got me. When I went to R3's room he was sitting on his butt on the floor. V18 said V17 told me he was transferring R3 with the mechanical lift, the sling broke, and R3 fell slowly to the floor. V18 said he doesn't remember where the sling broke, but he does remember it was 2 of the hooks, "like a whole part broke." V18 said R3 sustained a skin tear to his left elbow area. V18 said cleaned R3's wound and applied steri-strips. V18 stated, "R3 ended up on the floor because the sling completely snapped. I'm not sure how many staff were doing the transfer because I wasn't in there when it happened. I've never seen that happen before." On 7/5/22 at 2:21 PM, V17 (CNA) said he was transferring R3 with a total mechanical lift by himself. V17 said he looked at the sling before he started the transfer and didn't notice any concerns. If I would have noticed anything I would have replaced the sling. I was lifting R3, and he was over the bed a little bit and the front straps (by the legs) broke. He started to slide out. R3 was partially on the bed, so I put my knee there to slowly assist him to the floor. He didn't hit the floor hard. He slid from the bed to his butt. He cut his arm a little, but that was it. I went to tell V18 (R3's LPN) and he took care of it. On 7/5/22 between 9:00 AM and 4:00 PM, V9 (Licensed Practical Nurse - LPN), V10 (RN) and V12-V16 (CNAs) said there should always be two staff members during a mechanical lift transfer for resident safety. On 7/5/22 at 1:52 PM, V2 (Director of Nursing) stated, "There should always be two staff when	S9999		

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S9999	Continued From page 9 they perform a mechanical lift transfer for resident safety." V2 said if any staff member is unsure about something, they should ask for help. The facility's undated Safe Patient Lifting Policy showed, "Purpose: The Safe Patient Lifting Policy exists to ensure a safe working environment for resident handlers... Total Lift Transfer with 2 or more caregivers (Total Assist)... Laundry staff and all staffing with patient contact will conduct inspections of the slings; if slings are found to be impaired then the sling is to be removed from use..." (A)	S9999		