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
	IL6010391	A. BUILDING: ______ B. WING ______	C 01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCY REHAB AND CARE CENTER	100 ROSEWOOD VILLAGE DRIVE SWANSEA, IL 62220

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S 000	Initial Comments Investigation of Facility Reported Incident of December 10, 2022/155011	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b)5) 300.1210c) 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 300.1210 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. 5) All nursing personnel shall assist and	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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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 interview, record review, and observation the facility failed to provide safe transfers for 2 of 3 residents (R1, R2) reviewed for transfers in the sample of 3. This failure resulted in R1 and R2 receiving severe skin tears.

Findings Include:

1. R2's MDS dated 12/28/22 documents R2 is an extensive assist of one person for bed mobility, and total dependence of two staff members for transfers. R2 is moderately cognitively impaired.

R2's Skin Integrity Care Plan dated 1/10/23 documents use mechanical lift for all transfers, and a avoid shearing residents' skin during transfers, positioning and training. R2's Transfer Care Plan dated 9/30/22 documents Problem:

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S9999	Continued From page 2 Transfers from bed, chair and wheelchair was last reviewed on 1/7/23 documents resident (R2) will be assisted by 2 staff with mechanical lift. Staff to follow resident care card located in the closet. R2 sitting in her wheelchair in her room both of her legs are wrapped in gauze below her knee. She also was wearing pressure relieving boots on both feet. R2 stated, "I do not know how my legs was injured." R2's Event Report/ Investigation dated 12/10/22 documents V12 (an agency Certified Nurse Assistant/CNA) was caring for R2. V12 assisted R2 into her wheelchair. V12 observed that the resident's right shin was bleeding. She went to get V11 (Licensed Practical Nurse/LPN) and reported R2's leg was bleeding. V11 observed a skin tear R2's right shin and applied a pressure dressing. The resident denied any pain. V11 called the physician and the POA. The resident was transferred to (a local hospital.) The resident returned to the facility with sutures and an order for antibiotics. Upon investigation of the incident V12 stated that she had transferred the resident to the chair by herself, despite the care card indicating that the resident required the assistance of two staff for transfer. The agency was contacted and informed of the situation. It was requested by (the facility) that this CNA not return to the facility for any further shifts. The use of a mechanical lift will now be used for any transfers for R2. All direct care staff were in serviced that R2 requires (a mechanical lift) for transfers. V12 left the facility and did not write her statement, because she didn't know what happened. R2's Progress Note dated 12/10/22 at 6:40 AM documents (V12) came up to nurse's station and	S9999		

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stated, "I was transferring resident (R2) and she started bleeding and it's a lot". This nurse ran down to resident's room and witnessed a large amount of blood coming from resident left lower leg. Left lower leg had a 5-inch laceration noted. This nurse immediately applied pressure with a clean towel to site. This nurse stayed at bedside applying pressure to site, when another nurse came in and applied a pressure dressing to site. Resident (R2) had no s/s (signs and symptoms) of shock. Resident (R2) denies any pain. As other nurse stayed at bedside this nurse called EMS. EMS arrived at site. POA (V23) was contacted and was understanding. EMS transferred resident to (a local hospital). This nurse asked V12 how she transferred resident. V12 stated she self-transferred resident from bed to wheelchair. This nurse reminded V12 to check care card in resident's room that states resident is a 2-assist transfer not one. Nurse asked V12 to make a statement. On call nurse was contacted. DON (director of nursing) contacted.

R2's Progress Note dated 12/10/22 at 4:30 PM resident (R2) arrived at the facility by EMS from (a local hospital). Two EMS staff transferred resident into bed from stretcher lift. Resident came back with 12 sutures on the 5-inch laceration with a dressing wrap. Dressing should stay in place for 24hrs and not get wet. Change dressing as needed after 24hr. Hospital gave a referral to have a follow up appointment with V14 (Physician) in one week r/t (related to) laceration. New order for cephalexin 500mg capsule (by mouth twice daily) for 5 days. NP (Nurse Practitioner) informed. POA (Power of attorney) informed, DON contacted.

R2's Progress Note dated 12/13/22 documents (R2) seen on wound rounds today by V19 (NP),

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S9999	Continued From page 4 and she didn't like to look of bilateral heels. Decline seen since last week. R2 complaining of increase pain to legs. Resident doesn't have an appointment with V22 (Physician) until 12/22/22. V19 spoke with Physician office (V22) about concerns and possibility of no blood flow to bilateral lower extremities. V22's office agreed that she needs to be evaluated at the ER (Emergency Room). V19 spoke with V23 (POA). He also agreed to and wants his mom to be evaluated. A local Emergency Medical Service (EMS) was called to arrange the non-urgent transport. Called report to the local hospital. The local arrived at facility for transport. V23 was notified R2 on her way to the hospital. On 1/10/23 at 8:53 AM V11 (LPN) stated, "So that day I was the nurse on the hall. The night shift CNA (certified nursing assistant) from the agency ran down the hallway to state the resident was bleeding. She was the night shift, and I was the day shift nurse. I ran down the hallway and applied pressure to the injury. I could see she would need to be sent out. Another nurse held pressure on the injury, and I called the EMS (emergency medical services) and the family. I asked the CNA to write a statement, but she really didn't know what happened to make the residents leg bleed." On 1/10/23 at 11:19 AM V12 (CNA) stated, "I do remember that a resident hurt her leg on the XXX hall, but it was not my patient. I remember the CNA telling the nurse. No, I don't remember the CNA's name." On 1/10/23 at 11:00 AM V1 (Administrator) stated we asked the agency not to return V12 to the facility, because she transferred R2 by herself. She did not look at the care card.	S9999		

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2. R1's Minimum Data Set (MDS) dated 10/5/22 documents R1 is severely cognitively impaired. She is a limited assist of one staff for bed mobility and an extensive assist of one plus staff for transfers. R1's Skin Care Plan dated 10/5/22 documents Skin will be free from irritation redness and break down for the next 90 days. Sheep skin to bilateral side rails and use a draw sheet to turn the (R1).

A.
"R1's Event Report dated 12/27/22 documents The resident (R1) has extremely fragile skin that tears even when being turned. The residents(R1) recent tear resulted from transfer. From the bed to the wheelchair. Resident stated she didn't hit anything, nothing was bumped. In the past has refused to be (mechanical) lifted into the wheelchair. Staff talked to resident about changing to (mechanical lift). R1 is willing to do a try of mechanical lift. R1 is alert and responsive, and able to make her own decisions. Attempted both mechanical lift and (protective sleeves) resident R1 refused both, care card in place. Resident continues to be a 2 person assist if she gets up. Resident prefers to stay in bed. R1 obtained a 5.3-centimeter skin tear to the top of her right hand. R1's treatment is applied (brand name dressing) or hydrogel and wrap with (gauze wrapping).

R1's Progress Note dated 12/27/22 documents R1 obtained skin tear to top of right hand; area 5.3 cm; area cleansed with wound cleanser and (brand name dressing) and dry dressing applied; CNA informed this nurse while transferring resident she hit hand and obtained skin tear; NP notified; (V10) POA, notified; "this nurse spoke

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with resident (R1) about changing transfer status to (mechanical lift) to prevent further injuries while transferring" resident stated that she will try mechanical lift just not today; resident informed this nurse that we could attempt tomorrow after breakfast, nurse will do trial of mechanical lift with resident R1 tomorrow.

B.
R1's Final Investigation Report dated 8/8/22 documents the initial report was sent to your office (IDPH Office) on August 4, 2022, when R1 sustained a skin tear during repositioning. R1 was transferred to a local hospital for follow up care. Staff at the hospital cleaned and dressed the skin tear, no stitches or staples were needed. Upon return to the facility, our physician wrote orders for wound nurse practitioner to follow up with care. Nursing staff at facility were all given in servicing on proper repositioning techniques to ensure resident R1 safety and wellness to prevent any future occurrences. V3 and V4 (CNA) were given an Employee Counseling Records dated 8/4/22 and it documents while transferring a resident always make sure that all limbs' legs and arms are in a safe place to avoid injury.

V3's written statement dated 8/4/22 documents V4 and V3 were transferring the R1 from the bed to wheelchair once the resident R1 was in the wheelchair. We decided to pull her back a little more but didn't realize her arm was between the arm rest of the chair and her body. We grabbed the gait belt and moved her back, and afterwards realized she had a skin tear. We immediately told the nurse. During the whole transfer, the R1 was pulling away. We kept having to remind her she did not need to resist.

V4's Written Statement dated 8/4/22 documents

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S9999	Continued From page 7 V3 and V4 were transferring R1 from bed to chair using a gait belt. R1 needed to be pulled back into the chair so we did use a gait belt. We didn't notice her arm was in between the chair and her body. After we moved her back, we realized she had a skin tear. We told the nurse right away. During the entire transfer R1 was resistant we kept reminding her she was okay, and she wasn't going to fall. On 1/10/23 at 3:42 PM V4 stated, (R1) always leans back in her chair when you try to transfer her, and we were pulling her forward so we can transfer her, so when we sat her back down her arm got stuck between the arm rest and the chair. She got a skin tear we told the nurse. On 1/10/23 at 3:35 PM V3 stated, "We (V3 & V4) were trying to pull her (R1) up in the chair when her arm got caught between the wheelchair bar and the chair." The Facility Policy Skin Tears dated 3/2003 documents in order to limit the skin tears and adequately monitor residents skin tears. We will identify, document, treat, and investigate all skin tears. The (DON) Director of Nursing will initiate preventative measures. The Facility Policy Resident Transfer dated 7/2017 The facility will assess the resident to determine the safest method of physical transfer as a component of activities of daily living. "B"	S9999		