STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006597	A. BUILDING: _____ B. WING _____	12/02/2019

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S 000	Initial Comments Annual Licensure & Certification Survey Complaint Investigation #1948419/IL117552	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2 300.610 a) 300.1210 b)2)4) 300.1220b)7) 300.3240 a) 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	S9999	Attachment A Statement of Licensure Violations	

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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:

2) All nursing personnel shall assist and encourage residents so that a resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable. All nursing personnel shall assist and encourage residents so that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

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.

Section 300.1220 Supervision of Nursing Services
b) The DON shall supervise and oversee the nursing services of the facility, including:
7) Coordinating the care and services provided to residents in the nursing facility.

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S9999	Continued From page 2 Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. Based on observation, interview, and record review the facility failed to assess and provide restorative services to maintain range of motion (ROM) and prevent contractures for 1 of 2 residents (R55) reviewed for restorative services in the sample of 64. This failure resulted in decline of both of R55's upper and lower extremity range of motion and development of upper and lower extremity contractures. Findings include: R55's Minimum Data Set (MDS) of 4/24/18 documents R55 requires extensive assistance of two or more staff persons for Activities of Daily Living (ADL's) and that R55 does not walk in room or corridor during the assessment period. R55's MDS documents she has no range of motion impairments in her upper and lower extremities. R55's Care Plan dated 10/10/19 documents R55 is dependent upon staff for ADLs. R55's Care Plan documents her needs will be met through staff interventions through next review 1/2020. There is no documentation in R55's medical record that she has been assessed for restorative services related to her upper and lower extremity contractures. The Facility's Restorative Program Tracker dated November 2019 does not document R55 as receiving restorative services.	S9999		

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On 11/18/19 at 11:19 AM, R55 was in dining room. R55's arms were contracted with her left arm at her abdomen and her right arm across her chest. R55's legs were contracted at the knees at approximately a 30-degree angle that remained that way throughout lunch.

On 11/20/19 at 9:37 AM, V24, Restorative Nurse, stated R55 was discharged from hospice about a month ago. V24 stated hospice residents can receive restorative services. V24 stated R55 had been contracted in her upper and lower extremities since she (V24) began working at the facility in 2018. V24 stated the facility has 2 Restorative aides and they are trying to get more help for me. V24 states she and the restorative aides get pulled to the floor a lot. V24 stated residents who have had a stroke (CVA) or are on oxygen do not receive restorative services. V24 stated she thought this was company policy. V24 stated R55 was not receiving any type of restorative services including range of motion.

On 11/20/19 at 10:27 AM V25, Certified Nurse Assistant (CNA) stated R55 used to have braces for her contractures but she was not sure what happened to them. V25 states sometimes he does Range of Motion on residents when getting them up, but he doesn't do restorative program exercises and R55 does not get any.

On 11/21/19 at 9:27 AM, V2, Director of Nursing (DON), states facility has a restorative nurse (V24) and she goes around and views the whole facility and sees if there is any problems or issues that need to be added or taken off. V2 states V24 talks to staff and brings to morning meetings and works closely with therapy for individualize plans. V2 states Hospice is not picked up by restorative,

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or anyone on oxygen or that has had a CVA- they are not restorative services. V2 stated R55 came in about 2 years ago walking independently and that R55 has slowly declined. V2 stated "(R55) is on (V24's) radar."

On 11/21/19 at 11:19 PM, V3, Assistant Director of Nursing, stated R55's MDS had been coded wrong for range of motion and confirmed R55 had contractures.

On 11/21/19 at 11:20 AM, V3, performed passive ROM to R55. V3 straightened R55's right leg, right arm and fingers using passive range of motion. V3 straightened R55's left leg and attempted to straighten R55's left arm but was unable, as R55 was crying. R55's upper right arm returned to her original positioning across chest and R55's fingers returned to a closed fist position. R55's bilateral lower extremities returned to knees bent in original position. R55 was unable to perform any range of motion independently. R55 yelling out upon V3 performing ROM. V3 stated in her professional opinion that R55 would not benefit from restorative services due to her diagnosis of dementia. V3 stated R55 does not have impairments for range of motion because she can straighten out her extremities with staff assistance.

The Facility's Nursing Rehabilitation/Restorative Care Policy, dated 10/09, documents "Rehabilitation or restorative care refers to nursing intervention that promote the resident's ability to adapt and adjust to living as independently and safely as is possible. Focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning. A restorative program should be started when a

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resident is admitted with restorative needs, but not a candidate for therapy, or when the need arises during the course of a stay."

(B)

2 of 2

300.610 a)
300.1210 b)5)
300.1210 d)6)
300.3240 a)

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

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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.

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.

Based on interview, observation, and record review the facility failed to provide safe transfer techniques to prevent accidents for 2 of 6 residents (R6, R199) reviewed for transfers in the sample of 64. This failure resulted in R199 falling during a transfer and sustaining a left thigh bone fracture requiring surgical intervention.

Findings include:

1.R199's Physician's Order Sheet, dated

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November 2019 documented she had diagnoses of Stroke with left-sided paralysis.

R199's Minimum Data Set (MDS) dated 8/19/19 documents R199 is cognitively intact with a Brief Interview Mental Status (BIMS) of 15. R199's MDS documents that R199 requires extensive assistance and one-person physical assistance for transfers, and toileting. R199's MDS documented she was not steady and only able to stabilize with staff assistance when moving from seated to standing position, walking, turning around, moving on and off toilet and surface-to-surface transfers.

R199's Care Plan dated 8/19/19 documents that R119 is at risk for falls related to her diagnosis of Stroke and her history of falls. R199's Care Plan documents that R199 requires extensive assistance with Activities of Daily Living (ADL), and transfers to wheelchair with one assist.

R199's Late Entry Departmental Note dated 11/11/19 at 10:50 AM documents that V12, Certified Nurse's Aide, called V3, Assistant Director of Nurse's to R199's room due to R199 fell in the bathroom. The notes document that R199's left leg was bent up behind the right leg and R199 did complain of pain. R199's notes document that R199 was transferred to the hospital by ambulance. The Note documented at 3:00 PM the hospital staff contacted the facility and stated R199 was admitted to the hospital with a fractured left thigh bone.

The hospital x-ray report dated 11/11/19 at 1:09 PM documents an acute comminuted displaced spiral fracture of the left femur (thigh bone).

R199's Departmental Note, dated 11/14/19

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documented R199 had surgery on 11/13/19 for her fractured left thigh bone.

The Facility's Investigation Report dated 11/14/19 documented "On 11/11/19 (R199) called for assistance to the bathroom in her room. CNA on duty, (V12) pushed resident's wheelchair to bathroom doorway. Resident locked her wheelchair brakes and stood holding the assist bar. Resident lost her balance and fell onto the floor. CNA did not have gait belt in place on resident." The Report documented that V12 and nursing staff were educated on proper use of gait belts after this incident.

On 11/19/19 at 7:30 AM V2, Director of Nursing (DON) stated that R199 was being assisted in the bathroom by CNA. V2 stated that R199 has a built-up shoe due to a previous hip replacement. V2 stated the CNA did not use a gait belt to assist R199 with the transfer and R199 fell. V2 stated staff had to be re-trained on the use of gait belt.

On 11/21/19 at 8:00AM, V12 stated that on 11/11/19, R199 was in her room in her wheelchair and turned on her call light and was taken to the bathroom. V12 stated that R199 did have a built-up shoe on one foot due to a previous hip surgery. V12 stated that V12 was an assist of one. V12 stated that R199 had both hands on the bar and started wobbling and fell. V12 stated that R199 was not moved and emergency staff called. V12 stated it is standard practice for staff to utilize a gait belt for transfers at this facility. V12 stated that she did not use a gait belt when transferring R199 to the toilet.

On 11/21/19 at 9:00 AM, V13, R199's Physician/Medical Director, stated a gait belt should be used for transfers as it gives staff

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another way of holding on to the resident to assist with the prevention of fractures. V12 stated he was not aware that staff did not use a gait belt for transferring R199 on the day she fell and fractured her femur.

The Facility Policy Transfer/Gait Belts, review date of 1/2015, documents the resident is transferred by grasping the secured gait belt to provide stability and balance during movement.

2. R6's Care Plan, dated 5/31/2016, documents, "Resident is at risk for falls related to diagnosis of Alzheimer's and impaired mobility. Resident is an assist of two for transfers. Place resident in bed or recliner after meals."

R6's MDS, dated 8/20/2019, documents R6 requires extensive physical assist of 2 staff for transfers.

R6's Morse Fall Scale, dated 11/19/2019, documents (R6) has a history of falls, impaired gait and is high risk for falls.

On 11/18/19 at 9:30 AM, V7 and V8, CNAs, transferred R6 to the bed from a reclining wheelchair using a full body mechanical lift. V7 and V8 applied the sling straps to the full body mechanical lift. V8 was operating the controls and started lifting R6 into the air. Once R6 was in the air V7 walked around to the opposite side of the bed and maneuvered the reclining wheelchair leaving R6 unattended and free swinging from the bed to the wheelchair.

On 11/25/19 at 9:45 AM V7 stated, "When transferring a resident. I put a gait belt on the resident. I always use a gait belt. You have to use a gait belt, or your back will be messed up like

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S9999	Continued From page 10 mine. When transferring a resident in the lift you have 2 staff. 1 person has the machine and the other person has the sling until the transfer is complete for safety and stability." On 11/25/2019 at 9:50 AM V12, CNA, stated "We use 2 people for the lift transfers. 1 person controls the lift and the other controls the sling." (Full Body) Total Lift Policy, dated 8/2016, documents "#11 Maintain contact with the resident in order to guide or steady the resident during lift, as necessary. #12 Maintain contact with the resident to steady and/or guide, as necessary. " (A)	S9999		