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F 323	Continued From page 15 with transfers and or ambulation." E14's personnel file contained a verbal counseling dated 8/14/12 for non use of gait belt with improper transfer.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.690a 300.1010h 300.1210b 300.1210c 300.3240a 300.3240b Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of	F9999		

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F9999	Continued From page 16 notification 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act) These requirements were not met as evidenced by: The findings include: Based on interview and record review the facility staff failed to report an incident of possible injury to R3 during a transfer for one of four residents in the sample. This failure resulted in a delay of eight days for medical assessment, treatment and identification of a fracture. This failure	F9999		

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resulted in R3 also being treated for pain which required repeated administration of analgesic and narcotic medications.

R3's October 2012 Physician Order Sheet (POS)lists diagnoses which included Paralysis agitans, Closed Fracture of Ankle, and Osteoporosis. R3's Minimum Data Set (MDS) dated 8/01/12 identified R3 with moderate cognitive impairment. R3 was independent in bed mobility and required limited assist of one staff for transfers. R3 required extensive assist of one staff for ambulation. The 9/04/12 significant change MDS identified R3 needed extensive assistance of two staff for transfers and documented no ambulation had occurred during the assessment period.

Nurse's Notes dated 8/08/12 11:30 am documented a new order for an X-ray of the right ankle. There were no previous notes for August 2012 or July 2012 that indicated the circumstances that resulted in a need for an X-ray of R3's ankle. The 8/08/12 notes document a portable X-ray was done on R3's ankle. The X-ray results dated 08/08/12 identified a "spiral fracture of the distal fibula". Nurse's notes dated 8/08/12 documented Physician Z3 was notified and responded with a new order for non-weight bearing to right ankle, and apply ice as needed. A walking boot was also ordered to protect R3's ankle. An 8/13/12 order for Tylenol 650 mg (milligrams) twice a day for Pain Management was received on 8/13/12.

According to the R3's Nurse's Notes and September 2012 Physician Orders, R3 remained

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non weight bearing, utilizing a hoyer lift for transfers until 9/25/12 when R3 became weight bearing as tolerated and received therapy eval and treatment orders.

On 10/22/12 at 9:50 am Administrator E1 was asked about the investigation of R3's ankle fracture. E1 stated he had to work backwards to determine how the fracture occurred. E1 found out during interviews that R3 had hit her ankle on the bed during a transfer with CNA E13 and E14. E1 stated on 10/22/12 at 10:10 am that R3 had complained of pain to therapy staff during ambulation and they reported it to the nurses and no one else.

Restorative Nursing records for August 2012 documented R3 was ambulated to meals 8/01-8/08/12 am. Physical Therapy Aide E11 confirmed on 10/22/12 at 10:30 am R3 continued to ambulate though she was complaining of pain. E11 reported R3's pain several times to nursing, then she reported the pain to her supervisor who ordered the X-ray.

On 10/22/12 at 9:00 am R3 was asked how she fractured her ankle. R3 stated "They" (did not know the staff names) were assisting her and told R3 to put her arms around the staff's neck, then staff twirled R3 around and R3 "hit her ankle on a pipe" on the bed. R3 stated they did not use a gait belt. R3 said " It hurt terrible, I screamed." R3 stated she walked on it a few days and later she got an X-ray and found out "it was cracked".

On 10/22/12 at 10:05 am CNA E14 stated during telephone interview, On (7/31/12) E14 was orienting with CNA E13. E14 was observing the

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transfer of R3. E14 stated E13 picked R3 up from the bed and "smashed" R3's ankle on the side rail. E14 stated the half rail was in the raised position and R3 was seated high in the bed. A gait belt was not used. E13 picked R3 up using a "bear hug" transfer. E14 stated R3 was in a lot of pain. E14 stated he did not report the incident. When E13 asked about reporting it to the nurse, E13 had told him that she was not going to report it, stating R3 would be "OK".

DON E2 confirmed on 10/22/12 at 10:10 am they did not realize R3 had a fracture until 8/08/12. E2 did not know why E14 and E13 did not report the incident to the nurse when it happened. E2 stated they had to work backwards during the investigation to find out when R3 was initially injured because the staff did not report the incident. E2 stated she did not find out about R3's injury until she came back from vacation on 8/13/12. E2 was gone from 8/03 until 8/12/12 and had to finish the final investigation upon her return.

E2 provided the Medication Administration Record (MAR) for Pain Medication for R3 for July 31, 2012 through August 2012 on 10/22/12 which documented R3 received no pain medication on 7/31/12. R3 received PRN (as needed) Vicodin 5-500 (mg) twice on 8/01/12 (nothing documented in Nurses notes for 8/01/12). R3 received PRN Vicodin on 8/08, 8/09, and 8/12 for pain. Scheduled Tylenol twice a day was started on 8/13/12. E2 confirmed on 10/22/12 at 3:30 pm that staff's lack of reporting resulted in a delay in medical assessment, treatment and identification of R3's fracture.

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Based on observation, record review and interview the facility failed to follow the plan of care for safe manual and mechanical transfers for two resident (R1,R3) sampled for falls in a total sample of four. This failure resulted in R1 receiving a shoulder dislocation and leg fracture and R3 receiving an ankle fracture.

The findings include:

1. R1's October 2012 Physician Order Sheet (POS) lists diagnoses of Osteoarthrosis, Difficulty Walking, Pain in Joint Lower Leg, Muscular Wasting and Disuse Atrophy. R1's MDS (Minimum Data Set) dated 10/02/12 identified R1 as cognitively intact, required extensive assistance of two staff for bed and transfers and was non ambulatory during the assessment period. R1 weighed 180 pounds and had unsteady balance.

R1's Fall Risk Care Plan dated 7/03/12 had an approach dated 7/06/12 "Fall intervention for fall on 7/06/12: Sit to Stand with Carrier Sling". Nurses Notes dated 7/06/12 documented "(R1) was being transferred with a Sit to Stand lift when (R1) lifted her arms straight up into the air, causing (R1) to begin sliding down. The CNA lowered (R1) to the floor". Notes document no injury occurred. The Transfer Assessment Tool dated 7/06/12 assessed (R1) as needing a stand lift transfer with the carrier sling.

The Care Plan had another intervention added on 9/19/12, "Fall intervention for fall on 9/19/12: "PT/OT (Physical Therapy and Occupational Therapy) to eval (evaluate) and treat. Transfer via Hoyer."

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R1's Nurses' Notes dated 9/19/12 5:00 am documents a Certified Nurse Aide (CNA), E9 was getting R1 up from bed to wheelchair using the sit to stand lift when the resident became agitated and removed her hand and swung her left arm out around the (sling) strap. E9 then placed her knee behind the resident and lowered the resident down onto R1's knees with the sit to stand to the floor mat. The notes document "resident c/o (complained of) left shoulder pain. No swelling or bruising. Resident asked what she did stated "I moved my arm out of that thing and it hurts!" Resident unable to rate pain continues to yell about pain.. Upon body assessment no injuries noted but holding her knees and complaining of pain..resident continues of c/o Left shoulder pain and states "I hurt all over". PRN (as needed) Norco 5-325 given at 5:12 (am)..for pain." The notes document the Power of Attorney and Physician were notified the resident was lowered to floor with the sit to stand at 6:00 am.

The Nurses Notes document R1 continued to complain of pain in shoulder and received PRN pain medicine on 9/19/12 at 3:00 pm refusing to hold on to the lift, at 5:30 pm refusing to feed self because sore, and 7:50 pm R1 was in bed yelling out about her arm, and received pain medication. R1's physician Z4 was notified about R1's continued complaints of pain on 9/19/12 at 8:00 pm and an order for an X-ray was given. A Portable X-ray was taken on 9/19/12 at 8:20 pm. The X-ray result showed R1 had a left shoulder dislocation. The notes document Z4 was notified and gave an order to send R1 to the Emergency Room. R1 was sent to the Emergency Room on 9/19/12 at 11:00 pm.

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F9999	Continued From page 22 Nurse's Notes document R1 returned from the hospital on 9/20/12 at 4:09 am with diagnoses of "Reduction of shoulder dislocation under conscious sedation...Left arm immobilizer in place". Nurse's Notes dated 9/21/12 noted R1 returned from an appointment with an orthopedic surgeon with new orders for X-rays of Right hip and bilateral knees. R1 received portable X-rays on 9/22/12. The Radiology Report dated 9/22/12 identified R1 had an "Acute mildly displaced supracondylar fracture" of the left knee. The facility Occurrence Report dated 9/19/12 documented CNA E9's witness statement that (R1) moved her left arm up and over the (sling) strap and when resident started to slide out of of sit to stand, E9 placed her knee behind the resident and lowered the resident to the floor mat then came and got the nurse. Nurse E7 stated during interview on 10/18/12 approximately 12:30 pm that she was working on 9/19/12 approximately 5:00 am when she was notified that R1 was on the floor on the mat in her room. E7 was told by the CNA E9 that during the sit to stand transfer R1 had thrown up her arms and started to slide. E9 got behind R1 and lowered her to the mat. E7 stated she assessed R1 for Range of Motion and Pain. R1 could move the left arm but was it was sore. R1 complained of pain to the knees. E7 stated R1 has arthritic knees and often complains of knee pain. E7 notified the Physician who told E7 to give R1 pain medication	F9999		

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and monitor R1 for pain. E7 stated she went off shift at 6:00 am and returned to work on 9/19/12 at 6 pm. R1 continued to complain of pain on the evening shift and was X-rayed and a fracture was identified.

Restorative Nurse E3 stated on 10/18/12 at 1:15 pm that she did the investigation of R1's incident . E3 stated R1 was to utilize a carrier sling for the sit to stand lift. E3 explained a carrier lift has additional leg straps that help support the resident. Restorative Nurse in training, E10 stated at that time, R1 started using a carrier sling in July 2012.

A demonstration of the use of a regular sit to stand sling and the carrier sling was done with Restorative Nurse E10 on 10/18/12 at 1:45 pm. The regular sling fastened around the lower back and abdomen could slide up when lifted with the lift to the arm pits, the carried sling had two leg straps that crossed between the legs and attached to the sling. When E10 was in the carrier sling she could take her arms out of the sling and lift her legs off the foot platform and the leg straps would support the weight. E3 and E10 stated the carrier sling was used when R1 was injured because the CNA floor sheet for September 2012, "Transfer Via Sit to Stand with Carrier Sling" section was signed off on 9/19/12 by E9.

Nurse E7 stated on 10/18/12 at 1:30 pm that R1 had been using the regular sit to stand sling, not the carrier sling during the incident on 9/19/12.

E9's personnel file contained a written warning dated 9/19/12 "Use of carrier sling did not use

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F9999	Continued From page 24 sling on resident -Return demonstration." the warning was signed by DON (Director of Nursing), E2. On 10/18/12 at 2:00 pm E3 was informed that E9 had received a write up for not using the carrier sling. E3 responded that she was not aware of that. On 9/19/12 at 3:00 pm DON E2 confirmed that she had spoken to E9 who had confirmed E9 had not used the carrier sling. E2 stated " All (E9) thought about was to get (R1's) arm down out of the sling". E2 told E9 regardless of the type of sling used, you never want to take a resident down onto her knees. E2 stated E9 made a bad decision considering R1's brittle bones and weight which resulted in the fracture. 2. R3's October 2012 Physician Order Sheet (POS)lists diagnoses which included Paralysis agitans, Closed Fracture of Ankle, and Osteoporosis. R3's Minimum Data Set (MDS) dated 8/01/12 identified R3 with moderate cognitive impairment. R3 was independent in bed mobility and required limited assist of one staff for transfers. R3 required extensive assist of one staff for ambulation. The 9/04/12 significant change MDS identified R3 needed extensive assistance of two staff for transfers and documented no ambulation had occurred during the assessment period. Nurse's Notes dated 8/08/12 11:30 am documented a new order for an X-ray of the right ankle. There were no previous notes for August	F9999		

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2012 or July 2012 that indicated the circumstances that resulted in a need for an X-ray. The 8/08/12 notes document a portable X-ray was done on R3's ankle. The X-ray results dated 08/08/12 identified a "spiral fracture of the distal fibula". Nurse's notes dated 8/08/12 documented Physician Z3 was notified and responded with a new order for non- weight bearing to right ankle, and apply ice as needed. On 8/09/12 Z3 ordered a walking boot for R3. R3 remained non weight bearing until 9/25/12 when she became weight bearing as tolerated and received therapy eval and treatment orders.

The August 2012 POS documented an order on 8/13/12 for Tylenol 650 mg twice per day for pain management. The August 2012 Medication Record showed R3 received PRN (As Needed) Vicodin 5-500 milligrams (mg) twice on 8/01/12. R3 received PRN Vicodin on 8/8,8/9, and 8/12. R3 started receiving scheduled Tylenol on 8/13/12.

On 10/22/12 at 9:00 am R3 was asked how she fractured her ankle. R3 stated "They" (did not know the staff names) were assisting her and told R3 to put her arms around the staff's neck, then staff twirled R3 around and R3 "hit her ankle on a pipe" on the bed. R3 stated they did not use a gait belt. R3 said " It hurt terrible, I screamed." R3 stated a few days later she got an X-ray and found out "it was cracked" and they put a big boot on her foot.

Director of Nurse's E2 was asked on 10/22/12 at 9:30 am for an incident report investigation for R3's ankle fracture. E2 stated she did not have an incident report in the computerized Risk

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F9999	Continued From page 26 Watch system as R3's fracture did not occur as a result of a fall. E2 stated Administrator E1 would have the investigation of fracture. Administrator E1 provided a copy of an initial "Report to Illinois Department of Public Health" dated 8/09/12 and a final report dated 8/13/12 regarding R3's fracture . The final report summary stated "(R3) was being transferred with one assist to bed on 7/31/12 and hit her leg on the bed. No complaints, redness or bruising noted. On 8/08/12, resident unable to stand or transfer. X-ray obtained with diagnoses of FX (Fracture) to distal fibula." E1's investigation notes documented on 7/31/12 R3's leg/knee banged while being put to bed. Staff involved were Certified Nurse Aide E13 and Orientee CNA E14. E1 stated on 10/22/12 at 9:50 am that he interviewed E13 and E14. E1 did not take any signed statements from the aides. The surveyor informed E1 R3 had stated that she had been transferred without a gait belt with her hands around the neck of the aid when she got hurt. E1 stated "That sounds right". E1's notes documented R3 had reported pain to therapy staff, and therapy staff reported the pain to the nurse but no one else. Restorative CNA E11 stated on 10/22/12 at 10:30 am R3 was on a restorative walking program. The restorative documentation showed R3 was ambulated to the dining room on days and evenings from August 1-8 2012. E11 stated R3 complained of pain in her ankle while ambulating and E11 had verbally reported this to Nursing Staff on several occasions (did not know specific dates). E11 then reported R3's ankle pain on	F9999		

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HERITAGE HEALTH-DWIGHT	**300 EAST MAZON AVENUE DWIGHT, IL 60420**

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F9999	Continued From page 27 8/08/12 to her Restorative Supervisor E3, who got orders for the X ray and they discovered the fracture. On 10/22/12 at 10:05 am CNA E14 stated during telephone interview, On (7/31/12) E14 was orienting with CNA E13. E14 was observing the transfer of R3. E14 stated E13 picked R3 up from the bed and "smashed" R3's ankle on the side rail. E14 stated the half rail was in the raised position and R3 was seated high in the bed. E14 stated E13 did not use a gait belt. E13 picked R3 up using a "bear hug" transfer. E14 stated R3 was in a lot of pain. E14 stated he did not report the incident. He asked E13 about reporting it to the nurse and E13 had told him that she was not going to report it, stating R3 would be "OK". DON E2 stated on 10/22/12 at 10:10 am that she interviewed E13 who told her E13 went up underneath R3 with a "Bear Hug" transfer in the bed when R3 hit her ankle. E2 did not know why E14 did not report the incident to the nurse when it happened. The facility "Gait Belt Policy & Procedure" dated 6/15/09 states "Gait belts will be used on all residents requiring non mechanical assistance with transfers and or ambulation." E14's personnel file contained a verbal counseling dated 8/14/12 for non use of gait belt with improper transfer. B	F9999		