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	145840	A. BUILDING _____ B. WING _____	04/18/2008

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TABOR HILLS HEALTH CARE FAC	1347 CRYSTAL COURT NAPERVILLE, IL 60563

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F 520	Continued From page 92 Several residents were identified with bruises of unknown origin, residents sustained fractures from staff inappropriately using the mechanical lifting devices and from improper transfer techniques. The Quality Assurance Committee did not evaluate, investigate thoroughly or make recommendations to prevent the reoccurrence of injuries from accidents. The Fall Committee failed to thoroughly analyze the reasons for the incidents and accidents and make recommendations to prevent a reoccurrence of accidents and incidents. On 4/14/08 at 11:00 a.m. the Immediate Jeopardy was removed when the facility took the following actions to reduce the severity to Level 2: All staff was trained including return demonstration on the use of mechanical lifts prior to their working on the units. All mechanical lift devices were identified, logged and inspected. A preventive maintenance plan was initiated and maintenance checklist was completed on each lift. All residents have been reevaluated on the need for mechanical lifting and /or transfers. The policies for accident / fall / injury prevention program and incident investigation and management were reviewed and revised. Nursing in-services began on 4/14/08. The policy for implementing procedures for the use total body lift and sit to stand lifts began immediately. Competency training and evaluations were initiated for nursing staff on pertinent nursing	F 520		

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F 520	Continued From page 93 procedures including proper use of gait belts. Quality Assessment and Assurance committee is comprised of the Medical Director, the Utilization Review Physician, Director of Nursing, Administrator, Director of Quality Assurance, Assistant Director of Nursing, Director of Therapy, Pharmacy Respresentative, Restorative Nursing, Social Services representative, admissions and the Infection Control Nurse. The committee will identify issues that necessitate action of the committee. Negative outcomes in the quality of care and services provided to our residents will be identified and corrective action will be taken to correct identified quality deficiencies. Quality assurance reviewed staff training completion percentage	F 520		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.650e) 300.1210a) 300.1210a)5) 300.1210b)6) 300.1220b)8) 300.3240a) 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 written policies shall be	F9999		

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F9999	Continued From page 94 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 a meeting. 300.650 Personnel Policies e) All personnel shall have either training or experience, or both, in the job assigned to them. 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest practicable physicial, mental, and psychosocial well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. 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 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. b) 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 resident to see that each resident receives adequate supervision and assistance to prevent accidents. 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the	F9999		

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F9999	Continued From page 95 nursing services of the facility, including: 8) Supervising and overseeing in-service education, embracing orientation, skill training, and on-going education for all personnel and covering all aspects of resident care and programming. 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 requirements are not met as evidenced by: Based on observation, record review and staff interview the facility failed to: 1. Develop systems to determine if a resident's accident was avoidable or unavoidable. 2. Evaluate whether the facility's systems provide an environment that is as hazard free as possible and minimizes the potential for harm. 3. Determine if the facility provides adequate supervision and assistive devices to prevent avoidable accidents. 5. Conduct a thorough assessment and develop plans of care to determine and identify residents at risk. 6. Implement individualized interventions including safe transfer and use of assistive devices. 7. Ensure the facility has an effective system to identify and correct problems. 8. Ensure assistive devices/equipment (e.g., mobility devices, mechanical lifts and transfer aids, bedrails, wheelchair equipment, call lights, belts) are used properly or according to manufacturer's specifications, and implement	F9999		

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F9999	Continued From page 96 interventions as planned to meet the residents' needs across various shifts. 9. Ensure a system is developed for staff training including agency staff to prevent avoidable incidents and accidents; 10. Ensure a system is developed to evaluate and analyze the information gathered from reports and identify the underlying causes of the accidents and/or risks. These failures resulted in: 1. On 8/1/07 due to an improper transfer R27 rolled out of bed, dislocated a shoulder, and sustained a fracture to hand after which an unstageable pressure sore developed from improper cast care. 2. R27 sustained a bruise, and on 7/19/07 and 7/20/07 slid to the floor from a sit to stand lift due to the improper implementation of physician orders. The staff used a sit to stand lift when the physician ordered use of a total body lift for the resident. 3. R16 sustained a fractured right leg during transfer. 4. R14 sustained bruises of unknown origin. 5. R15 sustained a fractured left arm. 6. R9 sustained an angulated fracture at the base of the left 5th finger on 06-17-07 and (b) a fracture of the right phalanx on 12-06-07. 7. R4 sustained a laceration on the left calf during transfer on 09-11-07. This laceration eventually became infected on 09-24-07. It was identified through record review, interview and observation that a potential for serious harm was related to: 1. Residents sustaining injuries and fractures. 2. Staff not following doctor's orders. 3. Not having effective systems in place to	F9999		

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F9999	Continued From page 97 ensure staff competency in caring for residents and in the use of equipment. 4. Not having systems in place to monitor staff performance. 5. Quality Assurance failed to thoroughly investigate incidents and accidents and make recommendations to prevent reoccurrences. This is for 8 of 29 residents (R4, R8, R9, R14, R15, R16, R21 and R27) and 4 residents (R90, R104, R131 and R190) from outside of the sample. Examples include: 1. Closed record review of R27 documented an incident report sent to the Department of Public Health about an 8/1/07, 5:00 a.m. incident. E30, the Certified Nurses Aide (CNA) reported to the nurse that while she was turning R27 in bed, R27 rolled off the opposite side of the bed. E30 stated R27 landed on her knees and was holding onto the bedrail with both hands. When the Nurse responded, R27 complained of a headache and stated she hit her head. R27 also complained of pain to her right shoulder and both hands. R27's skin assessment revealed discoloration to both knees and both hands. No swelling or discoloration noted to the right shoulder or head. R27 was immobilized and sent to the hospital for evaluation. The staff identified a skin tear to R27's right 2nd toe, complaints of pain to her bilateral knees, right shoulder, both hands and a headache. R27 was returned from the hospital with a diagnosis of a right shoulder dislocation with orders for an immobilizer to the right shoulder at all times except during bath. R27 also had a fractured left finger.	F9999		

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F9999	Continued From page 98 During the survey, E30 was interviewed about how the incident occurred. E30 stated to surveyors that she did not have R27 properly positioned in the bed when she began to turn R27 for care. E30 stated the siderail was up on the right side of the bed, the direction she was turning R27. E30 stated she turned R27 away from her and R27's leg went over the end of the bed and R27 went over the side rail onto the floor. R27's feet went over first and R27 was holding on to the siderail after going over the rail. A review of the clinical records documents R27 has had a decline in activity of daily living skills. A history of a chronic dislocation of her right shoulder and Macular Degeneration. R27 is considered legally Blind. The facility's proactive plan on 8/3/07 was to reposition R27's bed against the wall. There was no assessment to determine if the bed against the wall is used as an enabler or restraint for R27. E30 stated the incident was caused due to improper turning and repositioning of R27. As a result of this improper turning and repositioning, R27 received injury to her right shoulder a dislocation, and a fractured left ring finger. R27 had to wear a shoulder immobilizer for 4 weeks and a splint to the left hand and left ring finger. The facility continually documented R27's left hand was swollen. On 8/23/07, R27 was placed in an adult recliner and no assessment was available for its use. On 8/24/07, the nurse documented R27 had edematous middle and ring finger with ecchymosis and pain. R27's left arm with the immobilizer splint was edematous. The wrap and splint was removed to reveal an unstageable pressure ulcer to R27's	F9999		

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F9999	Continued From page 99 left wrist at the outer aspect of a bony area. The Pressure Ulcer Healing (PUSH) tool of 8/24/07 documented a score of (7) 4.1-8.0 centimeters. From review of the clinical record, R27 has had other incidents involving staff care. In an incident report dated 7/19/07 at 9:55 p.m. the nurse documented she was applying cream to R27's breast. R27 kept on complaining of pain when touched. Upon inspection, it was noted both outer sides of R27's breast had marked reddened purplish discolorations. Staff noted the injury was probably caused by using the sling on the standing lift during transfer. Staff documents R27 had a shower earlier that evening. The CNA noted bruising and redness to both breasts but did not report it. The documentation notes the standing lift was used to transfer R27 from the wheelchair to the shower chair. R27 was unable to hold onto the standing lift completely and the sling slid to R27's upper body before the transfer was complete resulting in bruising and pain. R27 receives an anticoagulant medication and care is to be given to prevent injury and bleeding. The incident plan was for therapy to reevaluate R27 for a more appropriate transferring device. Physician's orders were obtained for R27 to be transferred with a full body lift. A review of the clinical record and plan of care did not identify how the staff was to transfer R27 to prevent bruising or injuries due to the use of the anticoagulant medications. There was no assessment to identify what size of sling would be appropriate to use for R27's full body lift or sit to stand lift. The investigation of this incident was not thorough and did not include all factors to	F9999		

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F9999	Continued From page 100 prevent a reoccurrence of injuries to R27. On 7/20/07 at 5:20 a.m. the nurses notes documented another incident for R27. The report documents the nurse was called by the CNA and found R27 lying on the floor. The report notes the CNA was transferring R27 from the bathroom chair to the wheelchair when R27 slid down from the standing lift. The CNA lowered the lift to place R27 down to the floor. The report documents R27 has decreased strength and is unable to bear weight. R27 has physician orders for a full body lift. R27 was to use a full body lift for transfers according to interview with E2, the Director of Nurses. E2 was not aware of why the order was not carried out. The investigation is incomplete and does not address why staff was not aware of the transfer orders. 2. On 4/8/08, R16 was in bed and appeared alert and oriented. She does not verbalize when spoken to, however R16 will nod head in response to questions asked. R16 has multiple diagnoses of which Osteopenia, Cerebral Vascular Disease with right hemiparesis, Aphasia, Vascular Dementia are listed in her medical history. The facility noted that R16 requires an artifical right foot support for alignment because she is unable to utilize that foot independently. This information is documented in a 3/18/08 investigative report. The facility's fall risk assessment tool identified R16 to be a fall risk on 2/27/08. The facility investigation report for R16 for an incident on 3/18/08 documents the following. E24, certified nursing assistant, was preparing to	F9999		

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F9999	Continued From page 101 shower R16 on 3/18/08 around 8:30 a.m. and observed the right lower leg was swollen and painful to touch. E18 notified R16's physician who gave orders to send her to the emergency room. X-rays completed on 3/18/08 in the emergency room show a fracture of her proximal fibula, distal fibula, and tibia with a shift of mortis of her ankle. E18, nurse, was interviewed and stated she notified the physician and sent R16 to the emergency room. E18 denied having prior knowledge that she was made aware that R16 was experiencing any problem with dragging the right foot, unable to bear weight prior to being notified by the CNA (E24). E18 stated the night nurse briefed her before leaving that morning that the Rehab Nurse needed to evaluate R16 because she was having difficulty transferring. E18 stated to night nurse that she would do that. The investigation report completed with E24's interview provided the following information. E24 reported to E18 on the morning of 3/18/08 that R16's right leg was swollen and E18 told her to put the resident back to bed with the standing lift. E24's documented report notes that R16's right foot was turned inward and swollen at the inner knee and she noticed the resident was not wearing the right leg brace and frowned. E24 positioned R16 in bed, and put a pillow under feet. The 11 p.m.- 7 a.m. shift incident investigation report for 3/18/08 documented E33 (agency C.N.A.) stated she went to transfer R16 from the	F9999		

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F9999	Continued From page 102 bed to the wheelchair on the morning of 3/18/08 and found R16 could not bear weight, right foot was dragging, toes down. E33 notified E34 (night nurse) who directed her to transfer R16 to the wheelchair with the standing lift. There was no documentation in R16's medical record that E34 assessed or examined R16's right leg and foot before giving direction to E33 to transfer R16 from bed to wheelchair using a sit to stand lift. R16 has a physician order to wear an artificial foot support during the day and remove at hour of sleep. There was documentation on the medication administration record at 6:00 a.m. that the artificial right foot support was applied. The box was initialed, however E33 denied applying it on the morning of 3/18/08 according to E2. E2 stated during the interview with E33, she (E33) admitted that she did not apply R16's artificial right foot support before she transferred R16 on the morning of 3/18/08. E2 stated that E33 said R16's artifical foot support was present in the room but she did not know how to use it. E2 was asked to review the orientation/training and inservices E33 had received from the facility. E2 stated all agency staff orientation/training was kept in a separate binder. This binder was reviewed with E2. There was no orientation/training present to indicate E33 received orientation/training in transfers and use of transfer lifts. E2 was queried as to whether the facility received information from the contractural agency on what training E33 had received. E2 was unable to provide this to the surveyors. The facility concluded that the injury was caused by E33 not applying the artificial foot support and to no longer employ E33. There were no other	F9999		

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F9999	Continued From page 103 recommendations concluded from this investigation as confirmed by E19. E19 was asked if the actions of the nurses was evaluated to be proper. E19 indicated that this was not looked at. In summary for R16 the facility did not ensure that: a. The night nurse promptly evaluated R16 when she became aware of the change in condition of R16's right leg and foot and before directing the CNA to use the standing lift to transfer. b. The staff (E18 the Day shift Nurse and E34 the night shift nurse) took precautions to determine if R16 would be safer to transfer by using the standing lift, during the the morning of 3/18/08 by E24 the day shift CNA and E33 the night shift CNA. c. The agency staff (E33) implemented the interventions per care tracker guide and received orientation/training in transfers and transfer lifts. 3. On 12/30/07 at 5:00 a.m., per incident report, staff found R15 in her bed with a bruise and pain to her left shoulder. A 12/30/07 X-Ray showed fracture of left distal Humerus (Supracondylar). The facility investigation of the incident noted R15 may have "hit her elbow on something in the environment such as siderails when she was removing her clothes and briefs." The facility Restorative Nurse, E6 stated no one in the facility uses siderails on the bed. On 4/11/08 it was observed when the siderails were down the siderails were below the level of the mattress and were away from body contact with the resident. The facility social service documentation on 12/6/07 indicated R15 has been having behavior	F9999		

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F9999	Continued From page 104 concerns related to her repeated use of bathroom, disrobing and agitation towards staff; and this is new behavior for her. Per documentation in R15's Nurses Notes and Social Service Notes (9/12/07 and 12/6/07) the nursing staff was aware of R15's behaviors: repeated use of bathroom, disrobing, aggressive towards staff when directed, dozing on and off during days and awake at night. The facility did not evaluate R15's behaviors or environmental hazards such as siderails, and did not develop a plan of care with specific interventions. On 4/9/08 at 3:45 p.m., Z3, the Medical Director stated no one has seen how R15 got hurt; flailing arms, hitting bed, because of Osteoporosis all are speculations. R15 was on first floor Alzheimer's Unit and was moved to 2nd floor for closer supervision of her behaviors. R15 needs to be monitored closely, but given the circumstances the facility cannot afford 1:1 staff supervision. On 4/9/08 this concern was brought to the attention of the facility Administration staff. On 4/10/08 a care plan was presented, but the interventions did not include behaviors or environmental hazards. 4. On 4/10/08 at 9:00 a.m. E12, an Activity Aide was pushing R104 in her wheelchair without footrests on it. E12 asked R104 to pick up her feet. R104 did not pick up her feet and E12 continued to push her, which was a tipping hazard. E12 stated she does not know what happened to the footrests and said, "You can check with the Nursing Staff." The Certified Nurses Aide who got her up did not put the footrests on the chair.	F9999		

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F9999	Continued From page 105 On 04-09-08 at 12:50 PM, a CNA was observed pushing R104 in her wheelchair out of the large dining room. R104's right foot was in between the foot pedals and was dragging while the CNA was pushing her. 5. On 4/11/08 from 1:38 p.m. to 1:50 p.m. R131 was observed sitting in her wheelchair with footrests in 2 East hallway in front of her room at the end of the hall from the Nurses Station. R131's feet were not on the footrests. R131 was not properly positioned, was sitting in the chair at the tip of her buttocks, the foot rests were about six inches below R131's feet and she had her feet extended in such a way that the tips of her toes were barely in contact with the footrests. R131 was positioned in her chair in such a way that any of her body movements could make her fall from the chair. 6. On 4/11/08 at 1:55 p.m. R190 was seated in her wheelchair in the hallway in front of her room on 2 East. R190 has a bolster cushion on her right chair arm to prevent her from leaning. During this time of observation R190 leaned to the right and forward in such a way that she was at risk for falling. The nurses and Certified Nurses Aides (CNAs) passed by and no one intervened to reposition her safely in the chair. 7. On 4/11/08 at 2:05 p.m. E13, a CNA, and E14, a Nurse on Orientation, transferred R8 from the toilet to a wheelchair and from the wheelchair to her bed. During this process the staff did not use a gait belt when transferring R8 from toilet to wheelchair. The staff had the gait belt on when transferring R8 from wheelchair to bed, but E14 did not hold onto the gait belt and R8 was	F9999		

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	145840	A. BUILDING _____ B. WING _____	04/18/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F9999	Continued From page 106 unsteady on her feet and was leaning to the right where E14 was, posing a fall hazard. R8 has a physician order for use of wheelchair tippers after she fell forwards and sustained injury to her nose. To provide wheelchair tippers was written as an intervention in R8's plan of care for falling, but the wheelchair tippers were not installed until 4/14/08. 8. On 4/8/08 during the initial tour of the facility a sit to stand lift had base bar plastic covers that were shredded with exposed sharp edges, which is potential hazard for injuries to feet. 9. On 4/11/08 at 6:15 p.m. the survey team members inspected all six of the sit to stand lifts and the total body weight lifts in the presence of E1, the facility Administrator, E2, the Director of Nurses and E6, the Restorative Nurse. There were slings on the sit to stand lifts which were either large or medium. There was no evaluation to guide staff as to what size sling to be used for each individual resident based on their size. E6 stated she did not think about evaluating residents for properly fitting slings. E6 also stated there used to be a sit to stand lift that had a cushion adjustment option at the legs, but could not find the lift when inspecting. E6 stated that the maintenance might have removed that particular lift. 10. The survey team asked E1 if there is any record to show the mechanical lifts were inspected periodically for proper functioning. E1 stated that the maintenance staff reported to her that they repair the lifts whenever the Nursing staff reports to him that a lift is not functioning properly, but maintenance does not keep any	F9999		

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F9999	Continued From page 107 record of repair done to the lifts. 11. Review of R9's incident reports indicate the following injuries: - Incident report dated 06-17-07 reads: The Certified Nurse Aide rendering AM care noticed that the left hand was swollen and she appeared to be in pain. An X ray was ordered and revealed an angulated fracture at the base of the 5th finger. - Incident report dated 12-06-07 shows: The Hospice Aide had noted a small bruise on the right thumb. X-ray revealed fracture of the right phalanx. Review of R9's Activities of Daily Living Resident Assessment Protocol Summary dated 07-05-07 disclosed: Resident does not express herself verbally but will smile at staff when she is in good mood. She can easily get upset and display abusive behavior by hitting staff with her hand. She can be resistive to her care when staff assist her with her Activities of Daily Living. She needs extensive to total assist with Activities of Daily Living. Resident uses full body lift with 2 assist to transfer due to her unpredictable behavior and abrupt resistance to her care. R9's Cognitive Resident Assessment Protocol Summary dated 07-03-07 reads: She does display physically abusive behavior. She was noted hitting a staff member with her arm. She also can display resistive behavior when staff is assisting her with Activities of Daily Living. She stiffens up and holds on to the handrails of the bed. Her family was concerned about how she was being transported by the staff. In an interview with the Charge Nurse, E8, on	F9999		

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F9999	Continued From page 108 04-09-08 at 10:55 AM, E8 stated, "when she holds the rails it's too tight during transfer. She used to be combative if she doesn't want to get up and if she doesn't like the person she could be combative. Her right hand is better than than left. She had 2 fractures on the hand." On 04-09-08 at 11:00 AM R9 was placed in a full body mechanical lift. During the transfer from bed to the wheelchair, R9's left foot got caught in between the bar and the metal frame of the lift. R9 cried in pain and said, "aw, aw"! 12. Review of R4's incidents disclosed the following: (a) 09-10-07 at 5:50 AM she was recently diagnosed on 09-04-07 with Cerebrovascular Disease with left sided weakness. She requires extensive assistance X1 with transfer. Certified Nurse Aide reports that R4's left leg slipped and hit the legrest bracket of the wheelchair. Noted with laceration to her left leg. Was sent to Emergency Room for evaluation and returned with sutures to her left calf area. 09-24-07 nurses notes read: Paged Nurse Practitioner regarding resident right leg with sutures. Noted incision with scant drainage, surrounding area noted slightly warm with redness and inflammation ... start with Keflex (antibiotic). (b) 11-07-07 at 7:10 AM - Resident's Bathroom. Assisted resident to bathroom within a minute the resident decided to get off the toilet and fell. The nurse's notes reads: resident was assisted to the bathroom and according to the Certified Nurse Aide within a minute the resident decided	F9999		

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F9999	Continued From page 109 to get off the toilet and slid to the floor. Statement from the Certified Nurse Aide reads: At 7:04 AM, I sat her on the toilet and left her for privacy. I heard her calling for help. I found her in a sitting position on the floor. (c) 02-26-08 at 1:30 PM - Resident's bathroom Found resident sitting on the bathroom floor facing the door with back against the toilet seat. Both legs extended. Asked Certified Nurse Aide what happened, she verbalized resident was on the toilet seat then the Certified Nurse Aide turned around to get the towel placed on her wheelchair by the door. The resident got up and went down on her knees. 13. On 04-10-08 at 11:05 AM, the Certified Nurse Aide, E24, assisted R21 to the bathroom using a sit to stand mechanical lift. It was noted that E24 did not apply the strap around R21's calves. 14. On 04-12-08 at 1:00 PM, R90 was observed in the hallway in front of the nursing station. R90 was observed sitting on her wheelchair with her right foot dangling. 15. R14 has been assessed by the facility to be at risk for falls on 12/07 and 3/08. A siderail assessment dated 12/01/07 documents the use of bed alarm, bilateral siderails 1/4 rails, soft mat on the floor, and low bed as preventive measures for falls. The facility developed a care plan for R14 being at risk for falls and injuries 12/4/07 but did not follow it. Review of the incident reports for R14 showed that on 3/01/08, 3/04/08 and 3/10/08 the resident	F9999		