STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005037	A. BUILDING: _____ B. WING _____	11/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KING BRUWAERT HOUSE	6101 COUNTY LINE ROAD BURR RIDGE, IL 60521

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Z 000	COMMENTS Annual Licensure IRI of 11/21/11/IL55339	Z 000		
Z9999	FINDINGS LICENSURE VIOLATION: 300.690b) 300.690c) 300.1210b)5) 300.1210d)3) Section 300.690 Incidents and Accidents b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. 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	Z9999		

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Z9999	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. 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. These regulations are not met as evidenced by the following: Based on observation, interview and record review the facility failed to accurately assess the transfer needs, use the proper transfer mechanism, and use proper transfer technique for 1 of 3 residents (R1) in the sample of 11 reviewed for falls and fractures. This failure resulted in an improper transfer which caused a fracture of both lower leg bones of R1. Findings include: On 11/13/12 at 10:10am, R1 was transferred	Z9999		

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Z9999	Continued From page 2	Z9999		

from the reclining chair to the bed using the sling lift. At 1:50pm, E5 (Nurse Aide) stated R1 used the standing lift last year but was changed to the sling lift November, 2011 after sustaining a lower leg fracture during a transfer with the standing lift. At 2pm, E4(Nurse) stated the sling lift is for non-weight bearing residents, the standing lift is for residents that can bear some weight on their legs. E4 stated the standing lift has a place on the platform for each foot, and a padded shin guard for each shin. "Both feet and shins should not be placed into the same side."

On 11/14/12 at 11am, E2(Director of Nursing) stated R1 was not cooperative with the use of the standing lift and wouldn't let staff place feet in the correct position for its use. E2 stated that during the investigation, she found out that other employees also transferred R1 by placing both feet on one side of the platform and both shins in one padded side. "The proper way to use the standing lift is to place one foot in each slot on the foot board." E2 stated the staff should have used the sling lift since R1 could not be positioned correctly in the standing lift.

On 11/15/12 at 10am, E2 stated she was unable to locate or recall the names of the 10 employees that stated sometimes R1 is transferred with both legs in the same support.

Incident Investigation 11/16/11 of the incident on 11/10/11 documents "the CNA working with (R1) was unable to separate her legs into the EZ Stand leg supports due to resident's contractures and resident's resistance. Both legs were placed in one support and he began to lift her. She cried out in pain which she usually does whenever she is being transferred. The CNA heard a 'click' from her leg when put back into bed and called the

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Z9999	Continued From page 3 nurse. Upon examination the nurse observed bruising and a deformity of the left shin and pain upon movement." The investigation continues "four nurses and six CNAs were interviewed as to the routine transfer care provided to the resident. They sometimes are unable to separate her legs and have transferred her with both legs in one support." Radiology Exam Report 11/10/11 documents "fracture of the mid tibia and proximal fibula." KB Nursing Assessment dated 4/3/11, 7/20/11, 10/28/11, and 1/24/12 document R1 as "does not bear weight", the assessment is the same before and after the fracture. November 2011 Physician Orders document R1 is "up as tolerated". Resident Transfer Policy documents the nurse and nurse aides assess and determine lifting and transfer requirements. Residents who are non-weight bearing will be transferred with the sling lift mechanical device. EZ Way Stand manufacture's guidelines document the use of a shin pad strap to secure a patient's feet on the foot plate or shins in the shin pads. B 300.610a) 300.3240b) 300.3240c) 300.3240d) Section 300.610 Resident Care Policies	Z9999		

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Z9999	Continued From page 4 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 300.3240 Abuse and Neglect 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) c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. (Section 3-610 of the Act) d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act) These regulations are not met as evidenced by the following: Based on interview and record review, the facility failed to report in a timely manner an allegation of	Z9999		

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Z9999	Continued From page 5	Z9999		

sexual abuse and failed to follow the facility policy for abuse for 1 of 2 residents (R14) in the supplemental sample reviewed for abuse.

Findings include:

On 11/14/12 at 11am, the investigation of an alleged sexual assault was reviewed with E3 (Abuse Coordinator). The alleged sexual assault occurred on 7/15/12 at 12:57am, and was reported to the Director of Nursing on 7/18/12, 3 days after the alleged abuse occurred.
The initial report from the facility was faxed to the Regional Office on 7/20/12 at 2:31pm, more than 24 hours after the reporting of the incident to the Administrator.
The final report was faxed to the Regional Office on 8/7/12 at 10:01am, 18 days after administration was notified of the alleged sexual assault. E3 stated the initial report should be faxed within 24 hours of knowledge of the allegation and a final report within 7 days, and does not know why it was reported late.

On 11/14/12 at 11am, E3(Abuse Coordinator) stated the nurse thought the sexual abuse could not have happened after she looked into it, so the nurse did not report it to the administrator.
Abuse Investigation 7/20/12 documents the alleged sexual abuse occurred on 7/15/12 at 12:57am, but the nurse did not report it to the administrator until 7/18/12, 3 days after the alleged occurrence. "Because the nurse was confident that nothing had happened, she did not report the alleged incident to the Director of Nursing until July 18."

The initial report from the facility was faxed to the Regional Office on 7/20/12 at 2:31pm, more than 24 hours after the reporting of the incident to the

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Z9999	Continued From page 6 Administrator. The final report was faxed to the Regional Office on 8/7/12 at 10:01am, 18 days after the administrator was notified of the alleged sexual assault. E3 stated the initial report should be faxed within 24 hours of knowledge of the allegation and a final report within 7 days, and does not know why it was reported late. Policy titled Abuse documents "any report of abuse or neglect, whether it is alleged or substantiated, will be reported immediately to the Administrator regardless of the day of week or time of day" and "a preliminary report will be prepared and sent to IDPH (Illinois Department of Public Health) immediately and the final investigation report and findings will be completed and sent to IDPH within 5 working days of the initial allegation. B	Z9999		