### Final Observations

**Statement of Licensure Violations**

300.1210b)  
300.1210d)(6)  
300.3240a)  

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.

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. (Section 2-107 of the Act)

These requirements were not met as evidenced by:
Based on record review and interview, the facility failed to ensure appropriate transfer technique was followed for one (R4) resident of three residents reviewed for injuries during transfer. Improper transfer technique resulted in fracture of tibia.

Findings include:

Accident/incident report dated 1/13/14 for R1 documents, "Assigned C.N.A reported that resident complains of pain on right lower leg. According to C.N.A, he transfer resident to wheelchair 2 days ago and right leg got caught between side rail. He reported to nurse but no discomfort for 2 days. Now noted pain." Under description of incident, "Resident complained of pain to her right lower leg area, x-ray taken and showed degenerative arthritic changes with fracture of the distal shaft of the tibia." Employee report dated 1/13/14 documents, "transferred resident, resident leg got caught between foot/leg of wheelchair and 1/2 rails. Resident sustained injury." As a result of this injury R1 was admitted to the hospital.

On 1/15/14 at 11:30 am with the help of an interpreter, R1 stated, "Hurt (fracture) occurred during transfer because foot was dragging under bed."

On 2/14/14 at 10:05am E3(Certified Nursing Assistant at time of incident with R1) through interpreter) stated, "When stand she has no control over feet. When turning her, foot hooked. He didn't know hooked by wheel so when turning she said ah."

On 2/14/14 at 1:15 pm Z1(Physician for R1) stated, "No weight bearing. Not able to control
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Summary Statement of Deficiencies

Continued From page 2

feet. Had spiral fracture of tibia. He tried to move and fracture occurred. Need remind/retought how to transfer properly."

On 2/14/14 at 9:30 am E2 (Director of Nursing) stated, "She's alert. She can answer questions. On and off reliable. The way he described her leg got caught. Transfer from wheelchair to bed. Caught between wheel of wheelchair and foot of bed. You have to be aware of where feet are when transferring. He probably at that time not looking or aware of where her feet where during transfer. She loses control of her feet during transfer. 1/12 and 1/13 didn't get up. I believe break happened during transfer."