

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6010664	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/13/2014
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NAME OF PROVIDER OR SUPPLIER ST JAMES WELLNESS REHAB VILLAS	STREET ADDRESS, CITY, STATE, ZIP CODE 1251 EAST RICHTON ROAD CRETE, IL 60417
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S9999	<p>Final Observations</p> <p>STATEMENT OF LICENSURE VIOLATIONS</p> <p>300.610a) 300.1210b) 300.1210d)6) 300.3240a)</p> <p>Section 300.610 Resident Care Policies</p> <p>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.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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.</p> <p>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following</p>	S9999		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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S9999	<p>Continued From page 1</p> <p>and shall be practiced on a 24-hour, seven-day-a-week basis:</p> <p>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.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>THESE REQUIREMENTS WERE NOT MET AS EVIDENCED BY:</p> <p>Based on observations, interviews and record reviews, the facility failed ensure the use of gait belt during transfer of one resident (R1), which resulted in R1 sustaining a fracture to the right arm. Facility also failed to ensure proper use of gait belt during transfer for R3, R4 and R5 who were all reviewed for assistance of activities of daily living (ADL).</p> <p>Findings include:</p> <p>1. R1 is an 82 year old female who had multiple medical diagnoses to include Status Post Cerebro Vascular Accident (CVA) with Right Sided Paralysis and Osteoporosis.</p> <p>R1's Change in Condition Form Dated 3/16/14 indicated: Staff will not transfer R1 by holding under the right arm. Will place wheelchair to left of bed and assist R1 to transfer per Z1's (R1's family) request.</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>Nurse's Notes dated 5/5/14 at 5:00 AM indicated: R1 was being assisted up (from bed to shower chair in the bedroom) for shower. E5 (Certified Nursing Assistant/CNA) informed E4 (Nurse) that E5 put her left arm into under R1's right arm and then placed her (E5) right arm under R1's left arm/ waist area to turn R1 towards E5. While doing so a pop sound was heard per R1 from the right shoulder. Physician and Z1 (R1's Family) notified. R1 was sent to the hospital.</p> <p>E5's Incident Report statement dated 5/5/14 indicated: "On my last round in the midnight shift, I (E5) had to shower R1. The shower chair (back) was against the wall next to R1's bed to see it would not move. I had R1 in sitting position on side of bed. I placed my right arm under R1's left arm, and my left arm around R1's waist under her (R1) right arm. As I raised R1 from bed and as R1 uses her one foot to help pivot, we (E5 and R1) heard R1's right shoulder pop. So I sat R1 back down on bed and laid R1 down. I got E4 (Nurse), she called physician and called ambulance.</p> <p>Hospital Records dated 5/5/14 indicated:</p> <p>R1 is alert and oriented times three, and has expressive aphasia. R1 states she was being transferred by staff into the bathroom. Staff (E5) grabbed her arm. R1 felt a pop. R1 complains of right shoulder humerus pain.</p> <p>Radiology Report indicated: Acute comminuted and displaced fracture of the proximal humerus through the surgical neck.</p> <p>On 5/6/14 at around 5:05 PM, R1 was lying in bed (in the hospital). R1 was alert and oriented able to</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>express self. R1's right upper arm was covered with bruise. R1 stated staff grabbed her in the arm to transfer her (R1) in the shower chair then she felt and heard a pop from right shoulder, staff did not placed a gait belt on her.</p> <p>On 5/6/14 at around 5:10 PM, Z1 (R1's Family) stated, staff called Z1 at home and told her that staff were transferring R1 to the shower chair when they heard a pop. R1 was in a lot of pain when she got into the hospital.</p> <p>On 5/7/14 at 6:52 AM E4 (Nurse) stated, E5 (CNA) came up to her and reported about R1's incident. E4 did physical assessment, physician and family were notified. E4 added there was no gait belt on site, E5 should have used a gait belt during transfer.</p> <p>On 5/9/14 at 10:45 AM E8 (Nurse) stated, R1 was on a stand pivot assist with gait belt use.</p> <p>2. On 5/7/14 at around 6:10 AM, E9 (CNA) assisted R4 with morning care. E9 transferred R4 to the wheelchair. Gait belt was applied loosely and slipped above the waistline by the breastline during transfer.</p> <p>3. On 5/7/14 at 7:25 AM, E10 (CNA) assisted R5 with morning care. E10 transferred R5 to the wheelchair. Gait belt applied by the arm pit due to mass in the abdomen, however E10 assisted R5 up by single handedly holding the gait belt at the back of R5 with only E10's right hand while E10 was on R5's left side..</p> <p>4. On 5/7/14 at 7:45 AM, E11 (CNA) transferred R3 to wheelchair. Gait belt loosely applied by the abdominal area. E11 then assisted R3 up by holding the gait with right hand at the back of R3,</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>while E11's hand was holding R3 by her (R3's) right arm pit.</p> <p>On 5/7/14 at around 8:45 AM, E2 (Restorative Director stated, gait belt must be around the waist, snugged but not to tight and not too loose. Enough to slipped staff's fingers in between resident's body and gait belt. Staff should not lift resident under their arms. If staff lift resident under the arm can potentially cause bruising or dislocation in the arms/shoulders. Staff must look in the resident's care tracker for type of care resident should received, or CNA staff should ask the nurses for resident care information.</p> <p>On 5/7/14 at around 10:30 to 11:00 AM Z2 (Physical Therapy Area Manager) stated, use of gait belt is universal, it must be use by anyone/everyone who's being transferred with assistance, it is use to assist with transfer for resident who are unsteady. Gait belt is supposed to be around the waist. It should not be in the arm pit, if it's slipping up it's supposed to be re-adjusted. Hold front and back of gait belt for balance or bring resident to a standing position by grasping belt with both hands while remaining upright. Staff member to place feet apart, one foot forward than the other and slightly bend knees to assure solid posture. Z2 then demonstrated to surveyor this procedure.</p> <p>On 5/9/14 at around 10:55 AM E12 (Nurse) stated, she (E12) had been telling CNA staff frequently to use gait belt to the residents during transfer, because staff are not habitually using gait belt.</p> <p>Facility's Gait Belt policy and procedure indicated:</p> <p>When: Gait belt are to be used at all times while</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>assisting a resident in getting in/out of bed, on/off commode or walking in the room or on the unit.</p> <p>Where: Gait belts are placed snugly around the resident's waist.</p> <p>Why: Gait belts prevent injury of both the resident and caregiver and promote safety in the facility.</p> <p>How: - Gait belts are placed around the resident's waist.</p> <p>(B)</p>	S9999		