STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145999	A. BUILDING _____ B. WING _____	C 02/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROSSE POINTE MANOR	6601 WEST TOUHY AVENUE NILES, IL 60714

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaints 2090457/IL119344 - F689 cited 2090513/IL119400 - F689 cited Facility Reported Incident of 1/19/20/IL119577 - F689	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to use a mechanical lift as determined necessary by the resident's comprehensive plan of care during a transfer for one (R1) of three residents (R2, R3) reviewed for accidents. This facility failure resulted in R1 sustaining two, separate left lower leg fractures. Findings include: R1 is a 101 year old, nonverbal resident with diagnoses per POS (Physician Order Sheet) that include (but not limited to) Parkinson's Disease, Vascular Dementia, Age-related Osteoporosis, Osteopenia, and Lumbar Region Degenerative Joint Disease. 2/3/20 at 9:30AM, V1 (Administrator), stated, R1 has a fracture, and we (the facility) did report that	F 689	PLAN OF CORRECTION GROSSE POINTE MANOR Provider No. 145999/0045203 Survey Date: 2/6/2020 F689 SS=G Free of Accidents , Hazards . CORRECTIVE ACTIONS for all residents found to have been affected by the deficient practice: R1 received a left leg splint at SCH and transferred back to the facility with follow up ortho appointment. Left leg was kept immobilized and elevated, CMS checks were performed and pain assessment and treatment was and is being done. R1's level of transfer assistance has been	2/28/20

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

Electronically Signed | 02/20/2020

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F 689	Continued From page 1 to the State. We did an investigation of it, and it was found that the CNA's (Certified Nursing Assistants) involved (V3 and V8) had improperly transferred R1 on 1/18/20 before giving him a shower. Asked what type of transfer was recommended for R1 per his care plan, and what was performed by the CNA's, V1 stated that they did a two-person stand/pivot transfer instead of a two-person mechanical lift as ordered. 2/3/20 at 10:43AM, observed R1 lying supine in bed, sleeping, with the head of the bed elevated at approximately 35 degrees. R1's left lower leg had a moldable splint with cotton batting and ace wrapping applied to the leg, and was elevated on a pillow. 2/3/20 at 2:00PM, V2 (Director of Nursing/DON) stated, V3 told me she had improperly transferred R1. R1 is supposed to be a two-person mechanical lift. V3, with V8 assisting her, performed a two-person stand/pivot transfer from the bed to the shower chair with R1. Once V3 told me she did an improper transfer with R1, I didn't interview further because I knew what the cause of R1's injury was - it was due to the improper transfer. 2/3/20 at 3:00PM, V3 (CNA) stated, so we (V3 and V8) used a sheet under R1's knees while he was sitting on the side of the bed. We put our arms underneath each of his arms, and both of us took a side of the sheet from under his knees and then lifted him to the shower chair from the bed. Asked V3 why did you transfer R1 using a sheet instead of using the mechanical lift? - V3 stated, because I was looking for a mechanical sling, and I couldn't find one. I suggested using a sling under his knees to help move him. I know	F 689	reviewed and care plan is up to date. All staff have been re-educated on R1's care plan, including R1's transfer and assistance needs. IDENTIFY OTHER RESIDENTS with the potential to be affected: All residents could have been affected. 100% audit of all residents' care plans to ensure appropriate level of transfer assistance was conducted by the Restorative department in conjunction with the Therapy Department staff. MEASURES TO CORRECT THE PROBLEM: Therapy department in conjunction with Restorative department has reassessed each resident's functional and transfer status. All residents' care plans have been updated as needed to ensure appropriate transfer status is in place. Each CNA staff has been re-educated and tested for competency in providing appropriate transfer assistance. Disciplinary action has been performed to V3 and V8. V3 has been assigned to increased supervision for thirty days to monitor V3's performance of transfers, with supervision being provided by nursing and restorative. V3 was required attest in writing that she will follow all facility policies and procedures, careplan and Kardex going forward. Policies reviewed and revised include: Transfers, Training, Orientation, Abuse,	

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F 689	Continued From page 2 now that it was wrong, and I shouldn't have done that. On 2/4/20 at 11:20AM, V14 (Physical Therapist) stated R1's transfer status is a mechanical hoyer lift with two-persons and that R1's status was poor prior to his injury too. Transferring R1 as a stand/pivot versus his recommended two-person mechanical lift could harm R1, he does have osteopenia/osteoporosis. With a comminuted and spiral fracture, the injuries could of been caused as a result of an improper transfer. Some diagnoses do make a resident more susceptible to fractures, but it (a fracture) is usually due to a trauma injury to the bone. 2/4/20 at 12:30PM, Asked V9 (Physician) if R1's type of fractures (a comminuted fracture of the tibia, and a spiral fracture of the fibula) could have spontaneously occurred? V9 stated, R1's medical condition is fragile, he is bedridden - these (the fractures) had to have been caused by mishandling. I presumed the nursing staff mishandled R1 during care, the fractures are not going to occur spontaneously - these types of fractures have to have an extraneous force. Informed V9 of R1's transfer status being a mechanical lift with two staff persons assisting - V9 stated, Oh, I agree - he (R1) shouldn't be weight bearing, he is fragile. Review of R1's quarterly Minimum Data Set dated 10/28/19, Section G (Functional Status) documents R1's transfer status as total dependence on staff assistance, and his current care plan documents R1's transfer method as an extensive assist of two-persons using a mechanical lift.	F 689	Careplan and Kardex. Inservice education was performed for identification and suspicion of Abuse for 100% of nursing and CNA staff, and all other department staff will be educated for Abuse prevention, if not done so within the past six months will be done again. Housekeeping, Maintenance and Laundry departments will be trained on Abuse prevention by 2/28/20. QAPI PLANS TO MONITOR PERFORMANCE: QAPI was performed on 1/28/20 at 11am to address the improper transfer prior to the survey, but after the resident injury. Additional QAPI meeting to review survey findings is scheduled for 2/20/20 at 3:30 pm with Safety Committee , Medical Director and QAPI team to review finding of IDPH 2/6/20 health survey results. Safety Committee will meet weekly for four weeks to assess compliance with safe transfer techniques policies and protocols, then monthly if in compliance. If not in 100% compliance with safe transfer technique, weekly Safety committee meetings will continue until full compliance is achieved. QAPI committee has determined that a Restorative CNA must attend and will be added to the Safety Committee. DATE WHEN CORRECTIVE ACTION WILL BE COMPLETED: 2/28/20	

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F 689	Continued From page 3 Review of R1's medical chart notes R1 was being monitored for trace (slight) edema to his left lower leg on 1/18/20 and 1/19/20. A portable x-ray of R1's left lower leg/foot was obtained on 1/19/20 which indicated an "age-indeterminate" tibia fracture, and V9 was notified of the results. R1 began to exhibit discomfort and bruising to his left lower leg, and was sent to the hospital emergency room for evaluation on 1/20/20, returning to the facility on 1/22/20. Hospital x-ray report dated 1/20/20 notes R1 sustained a left lower leg fracture, stating the fractures as, "Acute, mildly displaced comminuted fracture of the distal tibial diaphysis" and "Acute, mildly displaced spiral fracture of the distal fibula."	F 689		