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	145433	A. BUILDING _____ B. WING _____	C 08/24/2021

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GROVE OF ST CHARLES	611 ALLEN LANE SAINT CHARLES, IL 60174

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F 000	INITIAL COMMENTS Facility Reported Incident of August 6, 2021/IL137218	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 interview and record review the facility failed to ensure safe practices when turning a resident in bed. This resulted in the resident falling out of bed and sustaining a hip fracture. This applies to 1 of 3 residents (R1) reviewed for falls during bed mobility from a total sample of 16. The findings include: According to the Electronic Health Record (EHR), R1 had diagnoses including heart failure, hypertension, peripheral vascular disease, diabetes, hyperlipidemia, arthritis, depression, other orthopedic conditions, morbid (severe) obesity, lymphedema, irritable bowel syndrome, long term use of insulin, personal history of poliomyelitis, bilateral primary osteoarthritis of knee, long term (current) use of aspirin, chronic pain, body mass index [BMI] 50.0-59.9, hereditary lymphedema, peripheral vascular disease, and fracture of neck of left femur.	F 689	Corrective action for residents affected: R1 was sent to the hospital for an evaluation and is at the facility currently in stable condition. How other residents of the facility were identified to potentially be affected by the practice are: All residents have the potential to be affected by this alleged deficient practice. The facility has taken the following measures to ensure that the problem has been corrected and will not recur by: V6 has been re-educated on but not limited to the facility□s policy and procedure on resident safe handling policy The facility□s policy and procedure on resident transfers and assessments has been reviewed and staff have been educated on but not limited to this policy and procedure.	8/28/21

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

Electronically Signed | 08/31/2021

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F 689	Continued From page 1 The Minimum Data Set (MDS) dated 07/14/2021, showed R1 needed extensive assistance of two people for bed mobility, dressing, and toilet use. R1 was always incontinent of bowel and bladder. The MDS showed R1's cognition was intact. The MDS showed R1 was five feet six inches tall and weighed 335 pounds. A care plan showed R1 had an Activities of Daily Living (ADL) self-care deficit and impaired mobility with interventions including R1 required two staff participation to reposition and turn in bed initiated 11/25/2018; and R1 was totally dependent on staff for toilet use initiated on 05/27/2020. The Incident information provided to Illinois Department of Public Health (IDPH) showed R1 was alert and "oriented times two", able to follow directions, was non-ambulatory, and transfers using a total body mechanical lift. (R1) requires extensive to total assistance of two persons for ADLs and used a trapeze and grab bars for repositioning. On 08/06/2021 around 12:48 PM, CNA (Certified Nursing Assistant) was providing peri care when R1 repositioned herself to her right side, crossed her left leg over her right leg as she turned to the right side, lost trunk control and rolled all the way out of bed landing on both knees. R1 was grabbing the half bed rail at the time and had a low air loss mattress. On 08/23/2021 at 1:00 PM, R1 was awake lying in a bariatric bed with an air mattress, approximately one foot away from the wall. The bed was elevated with the top of the mattress	F 689	All residents have been re-assessed for bed mobility and their care plans have been updated. Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are: The DON and/or designee will conduct an audit three times a week to ensure compliance. ¿This will continue for the first month. All identified trends will be reviewed by the monthly QAPI committee and a plan will be discussed and implemented until resolution.	

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F 689	Continued From page 2	F 689		

approximately 36 inches from the floor. R1 said she was recovering from hip injury from falling out of bed. When asked how she fell out of bed, R1 said she wasn't sure, but "Maybe the CNA wasn't paying attention." R1 said she was in a different room with a different air mattress which was not as wide as the current mattress. R1 said only one person was changing her incontinence brief and the CNA told me to roll onto my side. R1 said when she rolled to the side, she just kept rolling off the bed, her knees hit the floor, and she had to let go of the side rail she had been holding onto. R1 said now she won't let anyone help change her unless they have at least two people in the room to help. R1 said before sometimes they would use two or three people to assist her when turning in bed.

On 08/23/2021 at 1:31 PM, V6 (CNA/Activities Aide) said on 08/06/2021 approximately 2:00 PM R1 had put on the call light and said she needed the incontinence brief to be changed. V6 looked for another staff member to help but was unable to find anyone to assist her. V6 said R1 was on an air mattress, possibly a bariatric size mattress. V6 said R1 was laying on her back and was able to roll to her left side (toward the wall) better. V6 said she had R1 roll to the left side, V6 cleaned R1's bottom while standing behind R1 on the right side of the bed, then had her roll to her back. V6 went to R1's left side of the bed and told R1 "Now we need to roll over." V6 said R1 had crossed her legs, R1 grabbed the right quarter side rail, and started rolling over. V6 said "(R1) just kept rolling and I told her to stop rolling and tried to grab (R1) but was unable to stop (R1) from rolling out of the bed. (R1) landed on her knees then rolled onto her bottom in a sitting position with her back leaning against the bed". V6 asked R1 if she was

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F 689	Continued From page 3	F 689		

ok and R1 yelled "Get help! Get help!" V6 said R1 wasn't complaining of pain right away while she was on the floor or while the staff had gotten her into the total body mechanical lift sling, however R1 did start complaining of left hip pain when R1's leg touched the bed while lowering the lift sling to the mattress.

On 08/23/2021 at 1:49 PM, V7 (Registered Nurse/RN) said when she arrived to R1's room, "(R1) didn't say anything when I asked what happened. (R1) has a tendency to keep quiet when she is upset." V7 said at first R1 was quiet, not complaining of any pain while she was on the floor or while the staff was moving her to put the sling underneath R1 to move her into the bed. V7 said once they were lowering R1 to the bed was when R1 started complaining of pain on the left hip. V7 said normally R1 would have two or three people for assist with her care, especially since R1 was heavier. R1 needed assistance with one CNA on either side of her when turning her in bed for safety. V7 said R1 didn't have two people assistance and only one CNA was assisting her for incontinence care. V7 said, "The CNA should wait for assistance from another CNA."

On 08/23/2021 at 3:24 PM, V1 (Administrator) and V2 (Director of Nursing/DON) said R1 was on a 42-inch low air loss/alternating pressure mattress bed prior to her fall.

On 08/23/2021 at 3:49 PM, V8 (CNA) said during the night shift prior to the fall, R1 would activate her call light when she needed to be changed, usually around 3:30 AM or 4:00 AM. V8 said she would always bring in another CNA for assistance with the other CNA standing on the opposite side of the bed from V8. V8 said she didn't want to

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F 689	Continued From page 4	F 689		

take any chances with R1 falling.

On 08/23/2021 at 4:01 PM, V9 (CNA) said she would usually bring another CNA to help hold R1's legs while the other person was cleaning. V9 said "It was easier and to prevent her from falling off the side of the bed." V9 said R1 was about halfway capable of turning herself over and was able to hold the side rail. V9 said she may have only changed R1 once without assistance from another CNA and V9 would have turned R1 away from V9, not toward her.

A hospital X-Ray left hip radiograph dated 08/06/2021 showed R1 had an impacted fracture of the region of the left femoral neck with resultant migration of the left femur.

A hospital Computerized Tomography (CT) dated 08/07/2021, showed R1 had an acute comminuted fracture of the base of the left femoral head and extending into the neck. There is impaction and anterior apex angulation.

A hospital Operative Note dated 08/07/2021, written by V10 (MD/Medical Doctor Orthopedic Surgeon) showed R1 slid out of bed suffering an impacted left femoral neck fracture. Surgery was aborted and R1 was treated non-operatively due to R1's comorbidities and the inability to safely accommodate R1's size for surgery.

On 08/24/2021 at 12:02 PM, V13 (Attending MD) said R1's fracture happened from falling out of bed. V13 said R1 had "pretty much zero mobility on her own" and would need to use the total body mechanical lift. V10 reiterated saying he was not aware of R1 complaining of hip pain prior to the fall, "so I would think that the fall was the cause of

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F 689	Continued From page 5	F 689		

the fracture."

On 08/24/2021 at 1:19 PM, V14 (RN/V10's nurse RN) said according to V10, R1's fall caused the fracture, and the osteopenia would have been a factor in exacerbating it. V14 said V10 decided not to proceed with surgery due to R1's morbid obesity and underlying conditions.

On 08/24/2021 at 11:08 AM, V12 (Assistant Therapy Director/Physical Therapist PT) said she recommended two people for assistance with rolling and changing even prior to R1's fall from bed. V12 said she would recommend two-person assistance because R1 was on an air mattress and it would be a safety concern. V12 said R1's movement was very restricted, she had a history of polio, and cellulitis. R1 needed a lot of help for positioning and moving due to the air mattress and her size. V12 said even with the trapeze she would try to help with positioning, but she needed help with her lower extremities. R1 was very limited in mobility of her lower extremities, plus she had eversion (a condition of the foot being turned or rotated outward). V12 said R1's bed was in the high position and V12 does not recommend the bed being in the high position. V12 said she also felt the bed should be against the wall instead of being away from the wall due to a safety issue. V12 said from a therapy standpoint R1 should always have two people to assist with bed mobility and repositioning. V12 would always recommend the nursing staff to roll the resident toward the staff member, not away from them for safety concerns.

On 08/24/2021 at 1:53 PM, V15 (Licensed Practical Nurse/LPN Restorative Nurse) said if it is recommended to use two people for bed

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F 689	Continued From page 6	F 689		

mobility and positioning, then the staff should use two people. V15 said the staff should pull the resident towards them, not roll them away from the staff member because they wouldn't be able to stop them if the resident kept rolling. V15 said residents who are using an air mattress should always have two staff members to turn them in bed due to the slippery nature of the air mattress material and having only one sheet on it. V15 said, "The air mattresses are just too slippery even for residents who can provide more assistance."

The United States National Library of Medicine Medline Plus dated 10/09/2019, showed the following steps should be followed when turning a patient from their back to their side or stomach: Explain to the patient what you are planning to do so the person knows what to expect. Encourage the person to help you if possible. Stand on the opposite side of the bed the patient will be turning towards and lower the bed rail. Move the patient towards you, then put the side rail back up. Step around to the other side of the bed and lower the side rail. Ask the patient to look towards you. This will be the direction in which the person is turning.

The American Congress of Rehabilitation Medicine Caregiver Guide and Instructions for Safe Bed Mobility dated 2017, included bed mobility refers to activities such as scooting in bed, rolling (turning from lying on one's back to side-lying), side-lying to sitting, and sitting to lying down. It also includes scooting to sit on the edge of the bed when preparing to stand or transfer. The instructions include to decide which side of the bed the patient should get out from based on their strength and position yourself to that side of the bed. The patient should always roll toward

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F 689	Continued From page 7 you not away from you. Patient safety included to assist the patient on their weaker side and if you are ever unsure, get needed help.	F 689		