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	IL6008130	A. BUILDING: _____ B. WING _____	C 09/17/2019

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S 000	Initial Comments COMPLAINT#s 1926706/IL115659 1926880/IL115851 Statement of Licensure Violations	S 000		
S9999	Final Observations 300.610a) 300.1210b) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies 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. 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	S9999	Attachment A Statement of Licensure Violations	

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care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

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.

These requirements were not met as evidenced by:

Based on observation, interview and record review the facility failed to safely secure a wheelchair in the facility van, failed to provide proper training to transport staff and failed to have a means of communicating emergency situations while in transit for one resident (R1) of three residents reviewed for falls in the sample of four residents.

This failure resulted in R1 sustaining a head and leg injury with acute blood loss requiring hospitalization.

Findings include:

Current Resident Face Sheet indicates R1 is 65 years old with diagnoses that include

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Acute/Chronic Respiratory Failure, Heart failure, Chronic Obstructive Pulmonary Disease, Morbid (Severe) Obesity and Long Term Anticoagulant Use.

Physician's Order Sheet dated 9/2019 indicates R1 receives warfarin (anticoagulant) 4mg (milligrams)every other day alternating with 5mg every other day.

Comprehensive Assessment dated 9/3/19 indicates R1 has no cognitive impairments and is a two person physical assist for transfers. Current weight in medical record indicates R1 weighed 392 pounds.

Occurrence Report dated 9/9/19 at 1:30pm indicates R1 had a fall during transport to an eye doctor's appointment; R1 sent to ER (Emergency Room) for evaluation and treatment.

R1's Investigation Interview/Statement taken on 9/10/19 at 4:20pm documents V10, Transport Aide loaded R1 into the van, however R1 was not sure all four straps were hooked. R1 indicated that as they were going down a hill, V10 stopped "a little abruptly" which "threw" R1 out of the wheelchair and the wheelchair then landed on its arm rests - upside down and with R1's head between the two front seats. R1 indicated that V10 asked R1 if he was in pain and if he wanted to go to the ED (Emergency Department). R1 indicates he told V10 that his leg was "killing" him but did not want to go to the ED and didn't want to miss his eye appointment. R1 indicates V10 was not able to get him up right away so she drove to the eye doctor and when the eye doctor looked at his leg he recommended that he go straight to the ED due to the swelling.
R1 indicates V10 drove him to the ED from the

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eye doctor due to the swelling in his leg. R1 indicates he was in excruciating pain while in the ED until "a sudden wave of relief" then looked down and saw blood everywhere coming from the back of his leg (calf area). R1 indicates his blood pressure dropped and continued to remain low and he needed to receive two units of blood. R1 indicates he does not know what hit his leg but it continues to be a "major problem." R1's statement indicates that he has two bumps on his head, but no brain bleed. R1 indicates V10 was not speeding, but couldn't really tell because his chair was facing backwards.

On 9/12/19 at 10:00am V10, Transport Aide/CNA (Certified Nurse Assistant) stated that she was the driver of the van on 9/9/19 when R1 fell out of the wheelchair on the van. V10 stated that she loaded R1 on the bus backwards with the back of chair facing her on bus. V10 stated that she was coming down a hill and R1's wheelchair was tipping backwards. V10 stated that she then slowed down because the chair was tipping back and when the van came to a stop, the wheelchair fell completely backwards with R1's head probably hitting the fire extinguisher which was on the floor between the two front seats. V10 stated that she felt R1's head and felt two bumps. V10 stated that she asked R1 if he was "Ok" and R1 said "yes". V10 stated that she asked R1 if he wanted to go to the ED and R1 said "no" - he wanted to go to his eye appointment. V10 stated that the eye clinic was about one block from the hospital. V10 stated there was no bleeding at that time, R1 was conscious and talking. V10 stated that she drove R1 - while R1 was still lying on the floor of the bus - to the eye clinic. V10 stated that when she arrived at the eye clinic she took R1's wheelchair down the lift and moved/slid R1's body to the side sliding door of the van, helped R1 sit

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up, then to a standing position and pivoted R1 to the wheelchair. V10 stated that she didn't use a gait belt because she didn't have one. V10 stated she was "freaking out" and wasn't sure what to do. V10 stated that she then took R1 into the eye clinic and drove back to the facility. V10 stated that when she arrived at the facility, she told V8, RN (Registered Nurse) about the accident. V10 stated that V8 told her to tell V2, ADON (Acting Director of Nursing). V10 stated she called V2 to see if she should go back to pick up R1 but just left and when she arrived at the eye clinic, R1 was waiting outside in his wheelchair with an eye clinic nurse. V10 stated that she then loaded R1 back into the van and drove R1 to the ER. V10 stated that she waited with R1 several hours until she was told R1 was being held in observation due to the leg injury.
V10 stated that she is also a CNA (Certified Nurse Assistant) and if a resident fell in the facility, she would call a nurse before moving the resident and would use a gait belt to transfer a resident. V10 stated that she should have asked for help with R1 right away when he fell but she didn't have a phone and R1 wanted to go to his eye appointment.

On 9/14/19 at 11:12am V8, RN (Registered Nurse) stated that V10, CNA came back to the facility (after dropping off R1 at the eye doctor) and stated that R1 fell while driving R1 to the eye clinic and that she left R1 at the eye doctor. V8, RN stated that she immediately gave V10 a statement to fill out and to go see V2, ADON (Acting Director of Nursing). V8 stated that she then called V2 and told her that R1 was on warfarin and that V10 said R1 hit his head. V8 stated that she did not tell V10 to go back and transport R1 to the ED and doesn't know who told her to do that. V8 stated "I would expect if

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someone falls 'off grounds', 911 should be called." V8 also stated that the previous transport staff had a van phone, so assumed there was still one on the van.

On 9/12/19 at 10:15am V2, ADON stated that V8 told her that R1 fell on the van and hit his head so she was concerned about R1 being on warfarin. V2 stated that she asked for the name of the eye doctor to tell them what happened and inform them that R1 was on warfarin. V2 stated she talked to a nurse at the eye clinic and that the physician had already seen R1 and was sending R1 to the hospital. V2 stated that she never told V10 to pick up R1 and drive R1 to the hospital and stated "(V10) just did it on her own." V2 stated that she was also not aware V10 drove the van to the eye doctor with R1 on the floor of the van after he fell out of the wheelchair and stated "should not have happened."

On 9/12/19 at 1:00pm V10 demonstrated how she secured R1's wheelchair in the van on 9/9/19. V10 placed the wheelchair in the van backwards, with the front of the wheelchair facing the back of the van. V10 placed strap hooks into the back two wheels. V10 stated that R1 did not have a wheelchair seatbelt and she did not apply a van seatbelt as she had not been instructed how to use it until this week. V10 described and demonstrated the placement of R1's head after the wheelchair fell backward. V10 indicated the back of R1's head was on top of the fire extinguisher that was on the floor between the two front seats. V10 stated that R1's entire body was on the floor of the van with R1's legs to his right side. V10 stated she moved the wheelchair away from R1 and drove R1 - while still on the floor of the van - to the eye clinic. V10 then demonstrated how she moved R1 - by herself - to

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the side door of the van and transferred R1 from the floor of the van to the wheelchair outside of the van - by herself without a gait belt. V10 stated that if a resident falls in the facility, staff notify the nurse right away and don't move the resident until assessed by the nurse.

Hospital Emergency Department (ED) records dated 9/9/19 at 3:32pm indicates R1 presented to the ER (on that date) for a fall and secondary right leg pain. Record indicates the fall on the van caused a large hematoma (bruising) with edema/swelling and pain to R1's right leg and two hematomas to right and posterior scalp. Record indicates R1 currently is on anticoagulant medication and was admitted for further observation.

Physician History and Physical Note dated 9/10/19 at 1:21pm indicates R1 sustained a fall during transport on the facility van and presented to the ED with posterior head trauma and significant large right leg hematoma "which was extremely painful." Note indicates that "overnight" R1 complained of severe leg pain which was suddenly relieved but then noticed bleeding from the area. Note indicates R1 had to be transferred to the ICU (Intensive Care Unit) due to severity of bleeding. Note indicates R1 required infusion of two units of blood due to the bleeding and Vitamin K to reverse the effects of the anticoagulant medication.

Hospital Physician Progress Notes dated 9/11/19 at 1:24pm indicates R1 continues with right lower hematoma with open wound and anemia of acute blood loss.
Physician Progress Note dated 9/12/19 at 0:32am indicates R1 continues with open area now requiring wound cultures (to rule out infection).

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Physician Progress Note dated 9/13/19 at 12:00pm indicates R1 started on IV (Intravenous) antibiotics.
Physician Progress Note dated 9/14/19 at 12:22pm indicates R1 with right leg burning pain and head pain.

On 9/12/19 at 10:15am V10, Transport Aide stated that when she started as transport aide in July (2019), she only had one day of training. V10 stated "I think I was trained wrong. I was trained to put hooks into the wheels but you're supposed to put the hooks into the frame of the chair". V10 also stated that she was not using "the red van seat belt - didn't know what it was for" and had residents facing backwards instead of forward. V10 stated that the staff who initially trained her is no longer employed at the facility. V10 stated that she didn't really have a supervisor until after R1's accident. V10 stated that after R1's accident 9on 9/10/19) she was retrained by V7, Maintenance Director and now knows how to correctly lock down the wheelchairs and use the seatbelt.

On 9/12/19 at 11:35am V7, Maintenance Director stated he had only been employed with the facility for 4 weeks and V10 was not "under him" until this week. V7 stated that V10 didn't know about the van seat belt or that the strap hooks need to be hooked to the frame of the chair, not the wheels because the wheels turn and it would not be secure. V7 stated that the red van seat belt needs to be applied whether resident has own chair seat belt or not as a safety precaution "Everyone that rides the bus should have a seatbelt." V7 stated that he had to do his own research to find out about the van and securing the wheelchairs because there was no instructions or procedures available when he was

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hired.

On 9/12/19 at 1:00pm V10 stated that she has been the only driver of the van since July (2019). V10 stated that when she started as transport aide, no one told her that she needed a phone. V10 stated that she just started using her own phone, but the day she transported R1 her phone wasn't available so she didn't have any way to call to report the fall. V10 stated that she never received any training on what to do if an emergency or fall happens on the van.

On 9/13/19 at 10:30am V11, Administrator stated that the facility transport van did have a phone but the previous transportation aide took it with her. V11 stated drivers should have some way to communicate with the facility or emergency services if a medical issue occurs.
On 9/17/19 at 11:15am V11 stated that R1 is still in the hospital and scheduled for wound debridement today. V11 stated that because R1 was on warfarin therapy "It really made the hematoma a lot worse."

No protocol, procedure or specific training was provided by the facility regarding instructions/protocol to secure wheelchairs and residents during transport, emergency/medical issues protocol/procedure during transport or training provided to transport staff.

(A)