STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005300	A. BUILDING: _____ B. WING _____	C 02/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWIS MEMORIAL CHRISTIAN VLG	3400 WEST WASHINGTON SPRINGFIELD, IL 62702

(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) COMPLETE DATE
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1010h) 300.1030a)3) 300.1210b) 300.1210d)3) 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident,	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 injury or change in condition at the time of notification. Section 300.1030 Medical Emergencies a) The advisory physician or medical advisory committee shall develop policies and procedures to be followed during the various medical emergencies that may occur from time to time in long-term care facilities. These medical emergencies include, but are not limited to, such things as: 3) Traumatic injuries (for example, fractures, burns, and lacerations). 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for	S9999		

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S9999	Continued From page 2 further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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 interview and record review, the facility failed to adequately assess/ monitor and call 911 for 1 of 3 residents (R2) reviewed for nursing care provided immediately following an injury. Additionally, the facility staff neglected to develop and implement a policy to address what procedures should be taken if a resident has potential head or spinal cord injury and failed to adequately assess/ monitor and call 911 for 1 of 3 residents (R2) reviewed for nursing care provided immediately following an injury. This failure resulted in R2 being moved and a delay in transport during change in mental status due to being thrown off of a mechanical wheelchair lift on a van. R2 sustained C6-C7 cervical fractures and subsequently died. Findings Include:	S9999		

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R2's Minimum Data Set (MDS) , dated 8/2/14, documents that R2 requires extensive physical assistance of one person for transfers and has severe cognitive impairment. R2's Care Plan, initiated 5/5/14, documents that R2 is at a risk for falls related to frequent fall history and recent fracture related to a fall at home.

R2's Progress Notes by E6, Licensed Practical Nurse (LPN), dated 10/21/14, documents, "Transport manager called this writer at (11:00 AM) stating resident (R2) had tipped off of transport lift onto ground outside in the parking lot. Resident (R2) was lifted approx. (approximately) 6 inches off of ground on lift and equipment malfunctioned. Upon arriving to parking lot resident was sitting in w/c (wheelchair) with his head down, chin toward chest. Resident (R2) talking to staff but speech was slurred. Alert and oriented x 3. This writer brought resident back inside and obtained vitals, WNL (within normal limits). Resident (R2) speech remained slurred and pupils fixed, nonresponsive to light. Hand grasps equal but weak. Resident c/o (complaint of) pain in left shoulder and pain in neck. (Physician) called at (11:20 AM) and gave order to send to (local emergency department) for eval (evaluation) and treat. (Local) Ambulance called and arrived at (11:45 AM), resident (R2) left facility at (11:50 AM) via ambulance to (local emergency department.)"

R2's Hospital Discharge Summary dated 11/6/2014, documents " He (R2) sustained injuries including a fracture of C7 and C6." The Summary documents "He failed his speech swallow study and was given a Keofeed and provided with nutrition by tube feeds. Ortho spine discussed the patient's situation with the family

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and the patient, and they opted for nonoperative course." The Summary documented the family chose not place a feeding tube and opted for comfort care and Hospice.

R2's Death Certificate, dated 11/6/2014, documents his cause of death as Respiratory Failure and Cervical Spine Fracture.

Risk Management Witness Interview Form, dated 10/21/2015, written by E9, LPN/Admission Coordinator, documented "Myself, CNA and other nurse assessed him (R2). Assisted him up to w/c. Staff talking to resident speech became garbled, looking (down) and not able to hold head up. Brought back into facility. Floor nurse came out to assess and speak to driver. Resident (alert and oriented x 2), pupils nonreactive, unable to hold head up, c/o (complains of) neck pain, S/T (Skin Tear) noted to L (Left) elbow , vitals obtained, resident fireman lifted to bed neck supported by ADON. Wife c (with) resident and aware. Hand grasps weak."

On 1/28/2015, at 12:15 PM, an interview was conducted with E6. E6 stated when she arrived at the incident site she was told R2 had fallen off the van lift. E6 stated R2's pupils were fixed and his chin was to his chest. E6 stated she had to take R2 back inside because she had no equipment to take vitals. E6 stated she noticed R2 wasn't himself so she asked another nurse to call the ambulance. When questioned why she didn't call 911, E6 responded " I had to get him in and assess him." E6 stated the staff told her when they got him up he was alert and oriented. E6 stated when she assessed him inside the facility he was alert but confused . E6 stated she told staff to put him to bed so the ambulance staff could transfer him to a board upon arrival. E6

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S9999	Continued From page 5 stated "He did seem to be having pain in his neck." On 1/29/15 at 8:45 AM E8, LPN/ Restorative Nurse was interviewed in regards to the incident on 10/21/14. E8 states that she was working on the 300 hall when staff called and said that R2 had fell off the lift. E8 stated that when she looked out the window he was in the wheelchair. E8 stated that by the time she got down there, they were bringing him down the hallway in the wheelchair. E8 stated the minute she saw him she knew there was something wrong. E8 stated that every time R2 would see her he would smile and say 'Hi' and give her a hug. E8 stated that she said 'Hi' to R2 and that he looked at her, but there was nothing there. E8 stated he was moaning in pain when laid in the bed. E8 stated R2 had a "goose egg" on the back of his head. On 1/30/2015, at 1:24 PM, an interview was conducted with E9, LPN/Admission Coordinator. E9 confirmed she was the first nurse on the scene of this incident. E9 stated she was made aware by the van driver and Z1, R2's wife, R2 had been thrown off the lift. E9 stated that R2 was alert and able to answer questions when she arrived to assess his condition. E9 stated "I noticed he had pitechia on his head." When questioned what that may have indicated, E9 responded "Possibly he hit his head." E9 stated she assisted R2 into a wheelchair. E9 stated R2's speech became garbled. E9 stated that is why the staff moved him inside of the facility so they could get a better assessment. E9 stated R2 stated his neck hurt. E9 stated the they transferred R2 into bed. When asked when staff would call 911, she sated "We call 911 if there was a true emergency."	S9999		

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On 1/30/2015, at 12:13 PM, an interview was conducted with E2, Director of Nurse's (DON). E2 confirmed through the conversations she had with those who witnessed R2's incident, R2 was thrown from the lift. When questioned why R2 was transferred twice, E2 responded R2 was alert and talking after the incident. When questioned what would be done if a resident could have sustained a head injury from an incident, E2 responded "I think assessment would be first." E2 stated the facility had no "911 Policy". E2 stated she always tells her staff if there is a question to call 911.

The website www.merckmanual.com on the topic "Spinal Trauma: Merck Manual Professional", printed on 1/30/2015, documents "Overall, nearly 48% occur in motor vehicle crashes, and 23% results from falls; however, falls are the most common causes in the elderly." The website documents "An important goal is to prevent secondary injury to the spine or spinalcord. In unstable injuries, flexion or extension of the spine can contuse or transect the cord. Thus, when injured people are moved, inappropriate handling can precipitate paraplegia, quadriplegia, or even death from spinal injury. Patients who may have a spinal injury should have the spine immobilized immediately; the neck is held straight manually (in line stabilization) during endotracheal intubation. As soon as possible, the spine is fully immobilized on a firm, flat, padded backboard or similar surface to stabilize the position without excessive pressure. A rigid collar should be used to immobilize the cervical spine." The website documents "Suspect spinal cord injuries in patients who have a high-risk injury mechanism (including minor fall in the elderly), an altered sensorium, neurologic deficits suggesting cord injury, or localized spinal tenderness."

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The Facility's Policy "Occurrence and Event Policy", revision date 5/14/2013, was reviewed. This policy did not address what procedures should be taken if a resident has a potential head or spinal cord injury.

(A)

300.610a)

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
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

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S9999	Continued From page 8 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 interview and record review, the facility failed to provide routine maintenance of the mechanical lifts on the vans to prevent potential malfunction for 75 of 75 residents (R1, R2,R7, R11-R21, R23-R83) that potentially use the van lift in the sample of 83. Additionally, the facility neglected to develop and implement policy/procedures and provide routine maintenance of the mechanical lifts on the vans to prevent potential malfunction. This failure resulted in R2 being catapulted from the van lift, sustaining cervical spine fractures, and subsequently dying. Findings Include: R2's Progress Notes by E6, Licensed Practical Nurse (LPN) , dated 10/21/14, documents, "Transport manager called this writer at (11:00 AM) stating resident (R2) had tipped off of transport lift onto ground outside in the parking lot. Resident (R2) was lifted approx. (approximately) 6 inches off of ground on lift and equipment malfunctioned. Upon arriving to parking lot resident was sitting in w/c (wheelchair) with his head down, chin toward chest. Resident	S9999		

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(R2) talking to staff but speech was slurred. Alert and oriented x 3. This writer brought resident back inside and obtained vitals, WNL (within normal limits). Resident (R2) speech remained slurred and pupils fixed, nonresponsive to light. Hand grasps equal but weak. Resident c/o (complaint of) pain in left shoulder and pain in neck. (Physician) called at (11:20 AM) and gave order to send to (local emergency department) for eval (evaluation) and treat. (Local) Ambulance called and arrived at (11:45 AM), resident (R2) left facility at (11:50 AM) via ambulance to (local emergency department.)"

The Facility Incident/Accident Report, dated 10/21/14, documents, (in part) "Per ER (emergency room) report, (R2) sustained a fracture to C6-C7 (cervical spine) and they were going to admit him overnight. There is no surgery planned at this time and it is anticipated that he will return to the facility."

R2's Certificate of Death Worksheet, certified 11/13/14 for date of death 11/6/14, documents, "Cause of death- a. respiratory failure due to (or as a consequence of): b. cervical spine fracture."

On 1/28/15 at 10:00 AM, E3, Driver, was interviewed in regards to the incident involving R2 on 10/21/14. E3 stated R2 was on the lift, and the lift went up approximately 6-12 inches, and the lift would not go up anymore. E3 stated he was beside the lift, not more the 2 feet away. E3 stated he called his boss from his cell phone, as phone was ringing, E3 stated he heard a spring effect sound, and R2 was catapulted from the lift. E3 stated the noise alone was what made him aware. E3 stated he was in shock. E3 stated R2 was thrown from the lift, out of the wheelchair, and onto the pavement on his left side. E3 stated

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that after R2 was thrown off the lift, then the lift did raise. E3 stated that the local handicap vehicle and mobility lift dealer said it was a bearing problem in the left arm of the lift. E3 stated he had problems with the lift before, as it would not go down. E3 stated that before the incident on 10/21/14, (the local city) Mass Transit District (MTD) did the work on the vans. E3 stated he did not think MTD worked on the lift, because it didn't get fixed. E3 stated the lift still would not lower. E3 stated after the incident with R2, the van was sent to (the local handicap vehicle and mobility lift dealer.)

The Service Manual for the (lift dealer) Century Series Public Use Wheelchair Lifts, dated August 2008, documents a maintenance and lubrication schedule. The Maintenance and Lubrication Schedule documents proper maintenance is necessary to ensure safe trouble free operation. The manual documents inspecting the lift for any wear, damage or other abnormal conditions should be part of all transit agency's daily service program. The manual documents the maintenance and lubrication procedures specified in this schedule must be performed by a (lift dealer) authorized service representative at the scheduled intervals according to the number of cycles (movement of the lift up and down one time) The manual documents that all listed inspection, lubrication and maintenance procedures should be repeated at "750 cycle" intervals following the scheduled "4500 Cycles" maintenance. The manual documents these intervals are a general guideline for scheduling maintenance procedures and will vary according to lift use and conditions. Lifts exposed to severe conditions (weather, environment, heavy usage, etc) may require inspections and maintenance procedures performed more often than specified.

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The manual documents to discontinue lift use immediately if maintenance and lubrication procedures are not properly performed, or if there is any sign of wear, damage or improper operation. The manual documents a black box warning that maintenance and lubrication procedures must be performed as specified by an authorized service technician. Failure to do so may result in serious bodily injury and/or property damage.

On 1/29/15 at 12:40 PM, Z5, (lift dealer) Service Representative was interviewed by telephone. Z5 stated that the maintenance described in the manual for lubricating and checking based on how many cycles is as important as getting the oil changed in your car. Z5 stated that if you don't take care of it, it will eventually bind up.

On 1/28/15 at 11:09 AM, E4, Transportation Supervisor, was interviewed. E4 stated the facility takes the vans with the mechanical lifts out for maintenance when necessary, and every six months for certification by Illinois Department of Transportation. E4 stated that the certification involves the vehicle and the lift. E4 stated that MTD does maintenance on the vans and lifts. E4 stated that is done on a schedule basis by MTD. On 1/29/15, E4 was interviewed at 2:29 PM. E4 stated that he was not aware of any problems with the mechanical lift prior to the incident on 10/21/14. E4 stated that he had no idea what a cycle was, and they normally do not take the vans with mechanical lifts in for maintenance unless there is a problem. E4 stated that is why the vehicles have a six month inspection by the Illinois Department of Transportation. When E4 was asked about the Illinois Department of Transportation Vehicle Inspection Forms not documenting any inspection of the mechanical

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S9999	Continued From page 12 lifts, E4 stated that he did not know how they do their inspections or what their inspection involves. On 1/29/15 at 8:45 AM E8, LPN/ Restorative Nurse was interviewed in regards to the incident on 10/21/14. E8 stated a few days or a week before the incident involving R2, she had heard it discussed in morning meeting that they were going to get the van with the lift serviced. On 1/29/15 at 11:48 AM, Z3, (the local handicap vehicle and mobility lift dealer) Service Personnel was interviewed by telephone. Z3 stated they always type what the customer says on the work order. Z3 stated in the notes that is why "jerky" is in quotations. Z3 stated they do not automatically schedule for routine maintenance. Z3 stated they offer an equipment mobility inspection that includes greasing, checking fluid levels, checking for loose screws and bolts. Z3 stated they only do the equipment inspections if the customer requests the service. Z3 stated when they repaired the facility mechanical lift , they did not do a complete inspection. The facility's (local handicap vehicle and mobility lift dealer) invoice, dated 11/19/14, documents that the customer noted that lift is "jerky" and stalls. The invoice documents that on 11/11/14 trouble shooting lift problem, checked electronics and all lift functions for possible failures. Nothing found. Loaded lift and found lift arms binding. The invoice states they notified (the lift dealer) technicians and ordered new lift arms. On 11/13/14 new lift arms were installed and they discovered a wrong part had been ordered, so correct part was ordered and finished installing the correct part on. The invoice documents that on 11/18/14 installed new lift arm, checked all levels and adjusted accordingly, loaded lift, cycled lift multiple times, all operations checked good.	S9999		

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	IL6005300	A. BUILDING: _____ B. WING _____	C 02/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWIS MEMORIAL CHRISTIAN VLG	3400 WEST WASHINGTON SPRINGFIELD, IL 62702

(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) COMPLETE DATE
S9999	Continued From page 13	S9999		

On 1/29/15 at 3:13 PM, E1, Administrator, stated, "There is a bit of a mix up in regards to we don't take the van in for general maintenance and it is taken every 6 months for the safety inspection, and of course if something needs fixed, it goes into (MTD), or (the local handicap vehicle and mobility lift dealer,) whoever is available."

The Cooperation Agreement between the MTD and the facility for Vehicle Repair and Maintenance Services (Regional Maintenance Program) dated 6/25/14 documents that MTD is a regional maintenance center designated by the Illinois Department of Transportation for the maintenance and repair of, among others, specialized equipment use on paratransit vehicles. The agreement documents scope of services under the agreement is to provide non-routine maintenance and repair services not generally available in the private sector for paratransit vehicles due to their specialized characteristics. However, the MTD will provide routine maintenance and repair services for items identified during the courtesy inspection, if desired by the agency. The agreement, under Courtesy inspection, documents when the agency vehicle is brought in, the MTD will perform a check-in courtesy inspection of the vehicle to assess its overall condition with particular attention to any problems identified by the agency. However, the MTD shall not be responsible for detecting any problems not identified by the agency.

Z4, Superintendent of Maintenance Mass Transit District, was interviewed on 1/30/15 at 10:25 AM. Z4 stated that MTD is a Regional Maintenance Center. Z4 stated they do not automatically schedule routine maintenance. Z4 stated they

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 14	S9999		

offer a preventative maintenance program and they suggest that customers schedule every 3,000 miles instead of going by cycles. Z4 stated that the facility does not take advantage of that program. Z4 stated that every customer is provided a copy of work that was done. Z4 stated that the Illinois Department of Transportation Vehicle Inspection does not include inspection of any equipment added to the vehicle. Z4 states that the inspection only includes the chassis.

On 1/29/15 at 10:51 AM, R1, a discharged resident that used the lift, was interviewed by telephone. R1 stated that while at the facility, he was going to an appointment on 11/19/14 and there was a problem with the lift. R1 stated the lift was going up, the lift stopped moving and would not go up. R1 stated the driver kept shaking the lift and pushing on it, and pushing the button. R1 stated the lift did finally go up.

On 2/5/15, E1 provided a list of current residents (R7, R11-R21, R23-R83) that "have the potential to use the van." In an interview on 2/5/15 at 2:56 PM, E1 agreed that these are the residents that use the lift on the vans.

The Facility had no documented policy regarding van lift routine maintenance.

(A)

PLAN OF CORRECTION

Attachment B
Imposed Plan of Correction

Lewis Memorial Christian Village
3400 West Washington
Springfield, Illinois 62702

Provider #: 146026 / 0021436
Survey Date: February 6, 2015
Survey Type: Complaint # 1540330/IL74425

The following Plan of Correction is submitted solely because it is required by law. This Plan of Correction is not an admission to any of the allegations made by the Illinois Department of Public Health's surveyor. Lewis Memorial Christian Village was in substantial compliance at the time of the survey and intends to request an informal dispute resolution conference to contest the alleged deficiencies. Nothing in this Plan of Correction is an admission that the facility could have or should have taken additional or different steps during the event in question.

F224
S/S=K

The facility ensures that it has written policies and procedures that prohibit mistreatment, neglect and abuse of residents as well as misappropriation of resident property. The facility ensures that it has policies and procedures to provide for routine maintenance of all equipment, including vans and mechanical lifts. Since the October 21, 2014 incident involving R2, there have been no issues or injuries related to the facility's van lifts and no issues or injuries from residents being transferred during transportation.

1. **Corrective actions for resident noted to have been affected by the deficient practice:**

   Immediately after incident, the resident was assessed by licensed facility staff on October 21, 2014. R2 no longer resides in the facility. (Attachments 1A).

   The facility's transportation supervisor interviewed the driver to review the procedure utilized with R2 to determine if the facility's policies and procedures were followed. All drivers were made aware of the lift issue and instructed not to use the van until repairs were completed.

   The maintenance schedule for the van was reviewed at the time of the occurrence to confirm that it had been properly followed.

   The van that was involved in the incident was taken out of commission until the lift could be fully inspected to determine the nature of the malfunction. The van was not returned to service until after the lift mechanism was repaired. (Attachment 1C).

   The incident was voluntarily reported to IDPH on October 21, 2014. (Attachment 1B).

2. **How the facility will identify other resident having the same type of need:**

All residents have the potential to be affected by this alleged deficiency.

3. **Measures the facility will put in place or change to ensure issue will not occur:**

All drivers were made aware of the lift issue and were re-educated on proper transfer procedures.

The facility implemented a procedure to ensure routine maintenance is completed on its vans and mechanical lifts. All drivers were trained on this procedure. (Attachment 3A).

The facility has performed ongoing inspections and maintenance on its vans and lifts. All necessary or regularly scheduled maintenance is being provided in accordance with the manufacturer's recommendations. The van involved in the occurrence was last inspected on January 30, 2015 for maintenance and returned to operation on February 6, 2015. (Attachment 3B, invoice dated February 6, 2015).

The facility reviewed its Occurrence and Event Policy with staff. The facility provided re-education to staff not to move any resident with a potential injury until the resident has been assessed by a licensed staff member. All nursing staff have received in-service training on the facility's Occurrence and Event Policy. All nursing staff received re-education on standard nursing practice not to move a resident with a potential injury until they have been assessed by a licensed personnel. (Attachments 3C).

4. **How the facility will monitor compliance:**

The DON will monitor ongoing compliance through direct observation of staff response to incidents and accidents as well as a formal review of the responses to all incidents and accidents for the next 4 weeks. Any failures by staff in their response will result in 1:1 retraining prior to the staff working their next shift and the failure will be reported to the QA committee for review and follow-up as needed. (Attachment 4A).

The Director of Transportation will monitor the maintenance schedule of the van to ensure that it is being properly followed. Any identified malfunctions or repairs will result in the van being removed from commission until repairs are completed. Any failure to conform to the maintenance schedule will be corrected immediately by the transportation director and reported to the Administrator for further action as needed. (Attachments 4B).

5. **Completion date:** February 7, 2015

acceptable

Attachment B
Imposed Plan of Correction

PLAN OF CORRECTION

Lewis Memorial Christian Village
3400 West Washington
Springfield, Illinois 62702

Provider #: 146026 / 0021436
Survey Date: February 6, 2015
Survey Type: Complaint # 1540330/IL74425

The following Plan of Correction is submitted solely because it is required by law. This Plan of Correction is not an admission to any of the allegations made by the Illinois Department of Public Health's surveyor. Lewis Memorial Christian Village ("Lewis Memorial") was in substantial compliance at the time of the survey and intends to request an informal dispute resolution conference to contest the alleged deficiencies. Nothing in this Plan of Correction is an admission that the facility could have or should have taken additional or different steps during the event in question.

F309
S/S=J

The facility ensures that each resident receives necessary care and services to maintain and attain their highest level of well-being. The facility ensures staff are trained to, and take steps to, initiate emergency services for residents when needed. Since the October 21, 2014 incidents there have been no issues with residents receiving emergency services after an accident or upon injury.

1. **Corrective actions for resident noted to have been affected by the deficient practice:**

   Immediately after incident, the resident was assessed by licensed facility staff on October 21, 2014. R2 no longer resides in the facility. (Attachments 1A).

   The incident was voluntarily reported to IDPH on October 21, 2014. (Attachment 1B).

2. **How the facility will identify other resident having the same type of need:**

   All residents have the potential to be affected by this alleged deficiency.

3. **Measures the facility will put in place or change to ensure issue will not occur:**

   The facility reviewed its Occurrence and Event Policy with staff. The facility provided re-education to staff not to move any resident with a potential injury until the resident has been assessed by a licensed staff member. All nursing staff have received in-service training on the facility's Occurrence and Event Policy. All nursing staff received re-education on standard nursing practice not to move a resident with a potential injury until they have been assessed by a licensed personnel.

4. **How the facility will monitor compliance:**

Attachment B
Imposed Plan of Correction

The DON will monitor ongoing compliance through direct observation of staff response to incidents and accidents as well as a formal review of the responses to all incidents and accidents for the next 4 weeks. Any failures by staff in their response will result in 1:1 retraining prior to the staff working their next shift and the failure will be reported to the QA committee for review and follow-up as needed. (Attachment 4A).

5. **Completion date:** February 7, 2015

Acceptable

Attachment B
Imposed Plan of Correction

PLAN OF CORRECTION

Lewis Memorial Christian Village
3400 West Washington
Springfield, Illinois 62702

Provider #: 146026 / 0021436
Survey Date: February 6, 2015
Survey Type: Complaint # 1540330/IL74425

The following Plan of Correction is submitted solely because it is required by law. This Plan of Correction is not an admission to any of the allegations made by the Illinois Department of Public Health's surveyor. Lewis Memorial Christian Village ("Lewis Memorial") was in substantial compliance at the time of the survey and intends to request an informal dispute resolution conference to contest the alleged deficiencies. Nothing in this Plan of Correction is an admission that the facility could have or should have taken additional or different steps during the event in question.

F323
S/S=K

The facility ensures the resident environment remains as free of accident hazards as possible and that each resident receives adequate supervision and assistance to prevent accidents. Since the October 21, 2014 incidents there have been no issues with the van lift or with residents being transferred during transportation.

1. Corrective actions for resident noted to have been affected by the deficient practice:

Immediately after incident, the resident was assessed by licensed facility staff on October 21, 2014. R2 no longer resides in the facility. (Attachments 1A).

The facility's transportation supervisor interviewed the driver to review the procedure utilized with R2 to determine if the facility's policies and procedures were followed. All drivers were made aware of the lift issue and instructed not to use the van until repairs were completed.

The maintenance schedule for the van was reviewed at the time of the occurrence to confirm that it had been properly followed.

The van that was involved in the incident was taken out of commission until the lift could be fully inspected to determine the nature of the malfunction. The van was not returned to service until after the lift mechanism was repaired. (Attachment 1C).

The incident was voluntarily reported to IDPH on October 21, 2014. (Attachment 1B).

2. How the facility will identify other resident having the same type of need:

All residents have the potential to be affected by this alleged deficiency.

3. **Measures the facility will put in place or change to ensure issue will not occur:**

All drivers were made aware of the lift issue and were re-educated on proper transfer procedures.

The facility implemented a procedure to ensure routine maintenance is completed on its vans and mechanical lifts. All drivers were trained on this procedure. (Attachment 3A).

The facility has performed ongoing inspections and maintenance on its vans and lifts. All necessary or regularly scheduled maintenance is being provided in accordance with the manufacturer's recommendations. The van involved in the occurrence was last inspected on January 30, 2015 for maintenance and returned to operation on February 6, 2015. (Attachment 3B, invoice dated February 6, 2015).

The facility reviewed its Occurrence and Event Policy with staff. The facility provided re-education to staff not to move any resident with a potential injury until the resident has been assessed by a licensed staff member. All nursing staff have received in-service training on the facility's Occurrence and Event Policy. All nursing staff received re-education on standard nursing practice not to move a resident with a potential injury until they have been assessed by a licensed personnel.

4. **How the facility will monitor compliance:**

The DON will monitor ongoing compliance through direct observation of staff response to incidents and accidents as well as a formal review of the responses to all incidents and accidents for the next 4 weeks. Any failures by staff in their response will result in 1:1 retraining prior to the staff working their next shift and the failure will be reported to the QA committee for review and follow-up as needed. (Attachment 4A).

The Director of Transportation will monitor the maintenance schedule of the van to ensure that it is being properly followed. Any identified malfunctions or repairs will result in the van being removed from commission until repairs are completed. Any failure to conform to the maintenance schedule will be corrected immediately by the transportation director and reported to the Administrator for further action as needed. (Attachments 4B).

5. **Completion date:** February 7, 2015

acceptable

Attachment B
Imposed Plan of Correction