

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6004840</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/25/2021</b>
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NAME OF PROVIDER OR SUPPLIER  <b>JACKSONVILLE SKLD NUR &amp; REHAB</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1517 WEST WALNUT STREET JACKSONVILLE, IL 62650</b>
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S 000	Initial Comments  Annual Licensure Survey	S 000		
S9999	Final Observations  Statement of Licensure Violations:  300.610a) 300.1210a) 300.1210d)3) 300.1210d)6)  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  a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the	S9999	<p style="text-align: center;"><b>Attachment A</b> <b>Statement of Licensure Violations</b></p>	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	<p>Continued From page 1</p> <p>resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)</p> <p>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:</p> <p>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 further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.</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>These requirements are not met as evidenced by:</p> <p>Based on observation, interview and record review the facility failed to implement interventions to prevent accidents, falls and elopements and failed to provide safe transfer techniques to prevent accidents for 5 of 8 residents (R23, R48, R69, R71) reviewed for resident care in the sample of 41. This failure resulted in R48 falling out of the wheelchair and sustaining hematomas to right and left chest and laceration to left elbow requiring hospitalization.</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>Findings include:</p> <p>1. R48's Electronic Medical Record (EMR) dated 5/24/21 documents diagnoses of Anemia, Long Term (Current) Use of Anticoagulants, Acquired Absence of Right Leg Below the Knee and Abnormal Coagulation Profile and Presence of Prosthetic Heart Valve.</p> <p>R48's Minimum Data Set (MDS) dated 4/16/21, documents R48 is cognitively intact.</p> <p>On 5/20/21 at 3:10 PM, R48 stated, "I was being transported to a doctor's appointment on 3/22/21 and the driver hit a curb, the driver did not lock my wheelchair or put a seat belt on me." R48 stated, "I flew out of the wheelchair and hit my chest on something. The driver stopped but was unable to get me back into the wheelchair (w/c)." R48 stated, "The driver told me to just lay on the floor until they got to the doctor's office. When we got to the doctor's office the driver went into the building and came back out with 2 nurses. They helped the driver get me back into the w/c." R48 stated, "The driver wanted to take me in the building for my doctor appointment, but the nurses told her, 'No, you need to take her to the hospital.'" R48 stated, "The driver was talking on the phone when she hit the curb. I didn't want to get her in trouble, so I didn't tell the facility she was on the phone. I just told them I saw the driver put the phone down." R48 stated, "My wheelchair was not locked, and I did not have a seat belt on."</p> <p>R48's Hospital records dated 3/22/21 document "A 48-year-old female with a history of mechanical valve on Coumadin, w/c bound presenting to the emergency department and declared a trauma consult after a motor vehicle</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>accident (MVA). Patient was an unrestrained passenger in a transport van when the van hit a curb along the road. Patient fell out of her wheelchair and complaining of left sided shoulder pain and chest wall pain as well as shoulder pain. No loss of consciousness (LOC). Patient is on Coumadin. Patient denies LOC, but does not remember the exact set of events, but was awake and alert on presentation and in vehicle per family member. Patient is complaining of left shoulder, left wrist and left chest wall and right shoulder pain."</p> <p>R48's Computerized Tomography Scan (CT) dated 3/22/21, documents, "CT Chest Impression: 1. There is a large left breast hematoma with overlying skin thickening and with active bleeding. 2. There is a hematoma involving the soft tissue of the anterior right shoulder and anterior upper right chest wall with multiple foci of active bleeding."</p> <p>R48's Left forearm x-ray, dated 3/22/21, documents, "Impression: Soft tissue swelling."</p> <p>R48's Left wrist x-ray, dated 3/22/21, documents, "Impression: Soft tissue swelling."</p> <p>R48's Hospital History and Physical, dated 3/22/21, documents "48-year-old female with a history of aortic and mitral valve repairs with mechanical valves, on coumadin, admitted as trauma consult after a fall out of wheelchair in moving vehicle. Left elbow laceration repaired by emergency department staff with nylon suture. Left elbow contusion, left wrist contusion, left chest wall hematoma and swelling, right underarm and chest hematoma and ecchymosis. Large 10 X (by) 10 cm (centimeter) area of ecchymosis on bilateral superolateral breasts with</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>no skin necrosis, tender to palpation. CT with bilateral chest hematomas, right with evidence of active bleeding."</p> <p>R48's Hospital Impression and Plan, dated 3/22/21, documents the following Trauma diagnoses: Head contusion, elbow contusion, elbow laceration, Left breast hematoma, and right shoulder hematoma.</p> <p>The facility's Verification of Incident Investigation/Administrative Summary, dated 3/22/2021 documents "resident was on transport van when van hit a curb and caused resident to shift out of wheelchair. resident is an assist of 1 person. Transport van pulled over and assisted resident back into wheelchair. Resident had no initial need to go to the hospital. Upon arrival to scheduled MD appointment, resident began to complain of pain and was transported to the ER for evaluation and treatment."</p> <p>V18's (Former CNA/Driver) Witness Statement, dated 3/23/21 documents, "I was driving the van down (street name) and I hit a curb and brought the van back on the road and then I looked in my mirror and the resident slid out of chair and was on the floor and so I was able to stop. I went and checked on the resident and she had a scrap on her ear and I looked at her whole body and nothing else was wrong and I asked the patient how she felt and she said she was having palpitations and we got the patient off the floor and put her in her chair and then went to the doctor office and she was telling the nurse she was having palpitations more and they told me to take her to the ER (emergency room) and I called the Director of Nurses (DON) when I stopped, to let her know what was going on. The resident was sitting on her bottom and she just had a</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>scrape on her ear and the chair was locked in place and the resident was sitting in her chair."</p> <p>On 5/25/21 at 8:25 AM, V2 Director of Nurses (DON) stated, "I would expect residents to be secured in the transport van. I was not aware (R48)'s wheelchair was not secured on the transport van or that she did not have the seatbelt on. We did not find any of this out until the resident was readmitted back to the facility from the hospital on 3/24/21. At that time, we had received her hospital records and were able to interview (R48) and found out what really happened. The Certified Nurse Aide/Driver (V18) was terminated because she did not follow Policy and she lied."</p> <p>On 5/25/21 at 9:30 AM, V1, Administrator, stated, "I did not know that the wheelchair and resident were not secured in the transport van until she was returned to the facility on 3/24/21 and we interviewed her and received the hospital records stating she was not restrained."</p> <p>On 5/25/21 at 12:50 PM, V24, R48's Physician, stated, "I would expect the staff to secure to wheelchair and resident when transferring residents in the transport van."</p> <p>The facility policy and Procedure for Crest Fleet Safety Program, dated 2/2021, documents "It is the policy to define guidelines regarding the purchase and use of company owned vehicles and to ensure that authorized drivers follow safe driving practice." The Policy and Procedures documents "Purpose: To provide guidelines for the purchase or lease of company vehicles; assure compliance with applicable laws; promote safety of employees and maintenance of company owned vehicles." The Policy</p>	S9999		

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documented "Driver safety regulations 1. The driver and all occupants are required to wear safety belts when the vehicle is in operation or while riding in a vehicle. The driver is responsible for ensuring passengers wear their safety belts." This policy documents "5. Cellular Telephones, Walkman's and Pagers. The following procedures apply to employees driving on company business who wish to use cellular telephones in the vehicle. A. External speaker and microphone must be included to allow hands-free operation. B. Phone number memory and programming capabilities are to be included. C. Drivers are to refrain from placing outgoing calls or responding to pagers while the vehicle is in motion. D. Incoming calls should be limited." The Policy documents "If transferring is NOT feasible: Secure the wheelchair (facing forward) to the vehicle floor. Use all 4 crash-tested wheelchair securement straps. Use crash-tested 3-point seatbelts for the wheelchair-seated rider. Protect the wheelchair rider. VERY IMPORTANT Provide effective restraint for the wheelchair passenger. Use a crash-tested pelvic and shoulder belt

2. R23's Care Plan, dated 5/24/2021, documents "At risk for falls and injuries r/t (related to) Medical Factors: Osteoporosis, Parkinson's, Cognitive Impairment, HX (history) of falls and Incontinence." The Care Plan documented the following Interventions: 1/12/18 Keep call light within reach; Nonskid pad to wheelchair; 5/24/2021 Provide/Reinforce use of assistive devices: Reacher (assistive device to reach objects and grab onto items); 10/21/2020 Soft touch call light to be utilized 10/6; 6/24/2020 Tab alarm when in chair (w/c & recliner) for safety.

On 5/19/2021 at 11:15 AM R23 was sitting in wheelchair. R23 had no personal alarm on her

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S9999	<p>Continued From page 7</p> <p>wheelchair or on her person. R23's personal alarm was sitting on table next to closet. R23's Reacher was lying on the foot of the bed covered by two blankets. R23's call light is not a soft touch.</p> <p>On 5/19/2021 at 12:50 PM R23 was assisted to the toilet. R23's alarm was not attached to R23. When R23 stood from the wheelchair, R23's alarm did not sound. There was nonskid pad in R23's wheelchair.</p> <p>On 5/20/2021 from 10:30 AM to 1:10 PM, based upon 30-minute observations, R23's alarm box remained on table next to closet. R23 did not have an alarm on herself or the wheelchair. R23's Reacher was on the bed with 2 blankets on top of it.</p> <p>On 5/24/2020 at 10:30 PM R23 was sitting in her room in her wheelchair with eyes closed. R23 was leaning forward and to the left. R23's head was beneath her knees sliding forward in chair. R23's call light was attached to R23's bed behind her and not in reach. R23's bed alarm was not attached to R23 and was located on the table next to the chair. R23's reacher was located on the recliner behind the wheelchair. R23 had no nonstick pad in her chair.</p> <p>On 5/24/2020 at 10:35 AM, R23 stated that she wanted to lie down but could not call for help because she didn't have her call light. R23 stated that when she does have her call light, she does have problems with pushing the button. R23 stated that at times she can't push the button. R23 stated that when her Reacher is at the foot of her bed it's hard for her to find and she can't use it if she can't find it.</p>	S9999		
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S9999	<p>Continued From page 8</p> <p>On 5/24/2021 at 10:40 AM V13, CNA, stated that she was not aware of the reason why R23's chair alarm was not on her. V13 stated that R23 has removed the alarm in the past. V13 stated that she was not here when the alarm was removed and didn't know why it hasn't been in place since Wednesday of last week. V13 stated that R23 should have an alarm box on her chair and a tab connected to her shirt. V13 stated that R23 was supposed to have her call light and Reacher in reach to keep her from falling. V13 stated that R23 does not have a soft touch call light.</p> <p>On 5/24/2021 at 11:15 AM V2, Director of Nursing, stated that R23 is supposed to have an alarm to her wheelchair and to her shirt. V2 stated that the Reacher should be in reach and behind her or at the foot of her bed covered by blankets is not in reach. V2 stated that R23 is supposed to have a nonskid pad in her wheelchair and soft touch call light in R23's reach. V2 stated that when an intervention is put in place, she expects the staff to make sure they are in place.</p> <p>3. R71's MDS dated 5/3/21, documents R71 requires a two staff assistance for transfers. It does not state in the MDS to use mechanical lift.</p> <p>R71's Care Plan, dated 5/5/21, documented R71 required two-person physical assistance required for transfers. R71's Care Plan does not document he uses a mechanical lift for transfers.</p> <p>On 05/19/21 at 12:05 PM, V4 and V5, CNAs, placed the mechanical lift sling under R71, secured the strap loops to the machine, raised R71 up over the bed, moved her over to the wheelchair, and lowered R71 down to the wheelchair. V4 and V5 failed to check the straps</p>	S9999		

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S9999	<p>Continued From page 9</p> <p>after raising R71 above the bed, failed to keep hands on R71 during lift, and failed to lock R71's wheelchair prior to the transfer.</p> <p>On 05/24/21 at 2:30 PM V20, Physical Therapist (PT), stated that "(R71) has been transferred using a full body mechanical lift since admission."</p> <p>On 05/24/21 at 3:16 PM, V1, Administrator, was questioned regarding proper use of the mechanical lift. When asked if she would expect staff to make sure straps are secure prior to lifting resident, she responded "yes". When asked if she would expect staff to lock the wheelchair, she responded "yes". When asked if she would expect staff to keep hands on the resident during the mechanical lift, she responded "yes".</p> <p>4. R69's Care Plan, dated 3/23/21, documents impaired cognitive function/dementia or impaired thought processes related to Alzheimer and Dementia.</p> <p>R69's Admission Nursing Assessment dated 3/23/21, documented moderately impaired decisions poor, supervision required and not to be considered an Elopement Risk Factors.</p> <p>On 5/19/21 at 9:45 AM, R69 was in her wheelchair. R69 propelled herself down the hall to the North-East exit door. R69 then used her left hand, placed it on the door below the door handle horizontal bar, then extended her right foot placed on the base, and was able to open the door. The door was not latching and therefore, R69 could open the door. R69 then used both hands and right foot to push the door open. At this time the door alarm sounded "North-East Door, North-East Door." A housekeeper approached R69 and returned her back into the building. The</p>	S9999		
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S9999	<p>Continued From page 10</p> <p>terrain outside the exit door is approximately 20 feet of concrete with an adjacent high traffic road and area hospital.</p> <p>On 5/20/21 at 10:15AM, state surveyor brought to V1's Administrators attention, that the North-East exit door is not latching with the door jam. State Surveyor showed V1 that the horizontal door handle must be pulled hard to provide a secure seal and completely shut the door. Without the seal, the door is can easily be open with a hand or foot without using the door handle. At 10:20AM, V1 stated she was not aware and would immediately address the issue with the maintenance department.</p> <p>The Facility's policy and procedure, entitled "Monitoring Wandering Resident", dated 9/15/19, documented, every effort will be made to prevent wandering episodes.</p> <p style="text-align: center;">(A)</p>	S9999		
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