STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004444	A. BUILDING: _____ B. WING _____	C 12/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTGOMERY NURSING & REHAB CTR	STATE ROUTE 127 HILLSBORO, IL 62049

(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
S 000	Initial Comments Complaint Investigation 2149390/IL141469	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 d)6) 300.3240 a) 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 care needs of the resident. d) Pursuant to subsection (a), general	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

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 are not met as evidenced by:

Based on observation, interview, record review, the facility failed to provide safe transport by failing to ensure a resident was secured in a wheelchair (R2) in a moving van, causing the resident to fall out of a wheelchair when the facility van turned a corner. This failure resulted in the resident receiving a facial laceration requiring sutures and bruising to face and top of legs.

Findings include:

1. R2's face sheet documents R2 had diagnosis of pneumonia, congestive heart failure, hypertension, cerebral infarction.

R2's care plan, dated 10/26/21, documents R2 is at high risk for falls.

R2's fall risk assessment documents R2 is at high risk for falls.

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S9999	Continued From page 2 MDS, (Minimum Data Sheet), updated 11/15/21, does not document BIMS score. Vehicle Safety Checklist, dated 11/16/21, documents vehicle was in satisfactory condition and good condition. All 8 safety latches, seatbelt, and lift all worked properly. Investigation completed by facility Administrator documents on 11/16/2021, V1 (Administrator) spoke with V3 (Certified Nursing Assistant/ Van Driver) regarding incident in the facility van with R2. V3 stated R2 was in her wheelchair and R2 and wheelchair were securely fastened in the van. V3 was transporting resident to local hospital for ordered tests. After V3 rounded a corner, he noticed that R2 was not sitting up in the wheelchair. V3 immediately pulled the van over to the side of the road to assess R2. V3 called facility and stated R3 was currently in the ER. On 11/16/2021, V1 spoke to V3 on 500 hall of facility at 11:30 AM regarding coming in the next day to reenact what happened during his transportation that caused R2 to be injured and go to the hospital. V3 said V3 had things planned for his day off, and V1 told V3 this was very important that he be here. V3 stated, "I'm done", with tears in his eyes, and threw the clean linen he was carrying on the floor. V3 then walked to the employee break room and clocked out and left the facility. On 12/21/21 at 8:30 AM, V1, Administrator, stated, "(V3, CNA, Van Driver) said he had (R2) strapped in correctly. (V3) stated he turned a corner and looked in rear view mirror and she (R2) wasn't there. (V3) took (R2) to the ER. The next day, (V1) had (V3) come in to re-enact what had happened. (V3) got tearful and threw down	S9999		

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S9999	Continued From page 3 some towels and walked out of the facility and quit." V2, Director of Nursing, stated, "I wasn't here when the incident with (R2) occurred. I was told that (V3) was transporting (R2) to the doctor's office. (V3) reported when he turned a corner, (V3) looked in the rearview mirror and he couldn't see (R2). (R2) had fallen out of the wheelchair and was laying on van floor. (V3) took (R2) to the ER. (V3) then called facility to inform them what had occurred. A few days later, (V1) asked (V3) to go to facility van and reenact what happened involving (R2). (V3) stated he quit and walked out." On 12/21/21/ at 8:30 AM, V4, Maintenance Supervisor, stated, "(V3) said he strapped (R2) in correctly." V4 stated, "There are 2 straps for the front of wheelchair and 2 straps for the back of the wheelchair. Then the actual seatbelt is used to strap across the resident." V4 stated V4 investigated the straps and seatbelt, and all worked fine. Attempted to contact V3, on several occasions. No answer and no voicemail available. R2's progress notes document: On 11/15/21 at 4:20 PM, call received from (V3), stating (R2) fell out of wheelchair and hit her head causing a bruise and head laceration. (V3) stated that he had (R2) in the ER at this time. On 11/15/21 at 7:50 PM, called local hospital for update on (R2). (R2) will be returning to facility. (R2) has 3 stitches to forehead. Received CT scan of the c spine, (Cervical Spine), bilateral legs and chest x ray were noted as all normal. On 11/15/21 at 10:35 PM, (R2) returned to facility via ambulance. Bruising noted to bilateral eyes. 3	S9999		

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S9999	Continued From page 4 cm, (centimeter), laceration to mid forehead with 3 stitches in place with mild bleeding. On 11/18/21 at 11:29 PM, Neuros continue due to fall. Facial bruising noted with laceration to forehead with 3 sutures. On 11/18/21 at 10:08 PM, (R2) admitted to hospice. On 11/25/21 at 8:00 PM, (R2) expired. R2's death certificate documents cause of death congestive heart failure and chronic kidney disease. Documents provided by facility include Van Wheelchair Seatbelt/Tie Down Training Checklist completed by V3 on 5/28/21. Transportation Policy documents Facility will arrange for transportation in the most cost effective and safe manner in order to assist residents and guests to physician or clinic appointments. (B)	S9999		