Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001044	A. BUILDING: ______ B. WING ______	C 12/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEBANON CARE CENTER	1201 NORTH ALTON LEBANON, IL 62254

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S 000	Initial Comments Investigation of Facility Reported Incident of Novebmer 15, 2022/IL153802	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 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 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.	S9999	Attachment A Statement of Licensure Violations	

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

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S9999	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to safely secure residents in the facility van during transport for 1 of 4 residents (R2) reviewed for accidents in the sample of 4. This failure resulted in R2 falling from her wheelchair during transport, sustaining a deep forehead laceration, fractured nose, and fracture of the neck and spine. Findings include: R2's Face Sheet, undated, documents R2 has diagnoses of Post subarachnoid Hemorrhage and seizure disorder. R2's Minimum Data Set (MDS), dated 08/19/22, documents R2 is moderately cognitively impaired and requires extensive assistance, one-person physical assist with transfer and locomotion off unit. It also documents mobility devices, wheelchair. R2's Care Plan, dated 08/26/22, documents R2 has a self-care deficit-needs supervision and/or assist to complete quality care and/or poorly motivated to complete Activities of Daily Living (ADL's) related to Cerebrovascular Accident (CVA), Subdural Hematoma (SDH), Diabetes Mellitus Type II (DM2). Resident requires extensive assist of 1 staff for bed mobility, transfers, toileting, dressing and hygiene. Uses wheelchair as assistive device. R2's initial report was submitted to the Illinois Department of Public Health (IDPH) on 11/17/22 and documented the incident occurred on 11/15/22. The Initial Report documents "Alleged motor vehicle incident in company van.	S9999		

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Investigation initiated. Final report will be sent." The Initial Report documented R2 received a laceration and fracture. The Incident documented that R2 was hospitalized on 11/15/22 at 1:00 PM.

A final report was submitted to IDPH on 11/21/22, and documents on 11/15/22, R2 was in the company van attending an appointment to obtain the COVID booster. The final report documented V4 (Van Driver/Certified Nurse's Aide) was at an intersection when the light turned yellow, and she decided to take caution and stop. The report documented "The resident (R2) fell out of chair onto van floor and hit her head. 911 were call to the scene and the resident was transported to the hospital. Upon my investigation, the driver and passenger, V3 (Certified Nurse Assistant/CNA), both stated that the resident was buckled into the van and was seated next to a friend talking. The driver (V4) replicated how and where the resident was positioned and buckled in. In conclusion, the driver (V4) was suspended pending investigation."

R2's Progress Notes, dated 11/15/22 at 1:00 PM, documents "Writer received phone call from V4 (CNA) in transportation. (V4) state resident was being transported via Emergency Medical Services (EMS) to Emergency Room (ER) after sustaining a laceration to forehead after falling forward out of wheelchair during transport. Writer notified Administrator, DON (Director of Nursing) and V7 (Power of Attorney/POA)."

R2's Investigation report done on 11/16/22 at approximately 10:00 AM, documents an interview with V4. R2's Investigation documented that V4 stated there were 4 people in the van including her, V3 (CNA), R1, and R2. The Report documented they went to (name of pharmacy) in

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S9999	Continued From page 3 a local town to get COVID vaccines for both residents (R1 and R2). The Investigation documented V4 stated the light turned yellow, and the driver (V4) applied brakes to stop at the intersection. The Investigation documented that V4 stated she had transferred R2. The Investigation Reported documented "The time was approximately 10:50 AM, when the resident (R2) fell from wheelchair to the floor hitting her head and creating a large laceration on her forehead. 911 was called and local police and ambulance showed up. Resident (R2) was transported to a local hospital from the scene. Upon return (V4) recreated the scene of how the resident (R2) was loaded into the van with Administrator (V1) and Maintenance (V8). It was noted that she (V4) did not have the resident (R2) secured in the proper position or equipment." R2's Hospital Emergency Department record from 11/15/22 at 2:45 PM, documents R2 had a non-contrast head Computerized Tomography (CT), and it documented chronic left extra-axial, extradural fluid collection that is stable from prior and thin strip of hyper density also stable from prior exam consistent with postsurgical changes. The CT also noted a comminuted minimally displaced fracture of the anterior nasal bone as well as left frontal scalp hematoma. CT of the cervical spine shows anterior inferior nondisplaced cervical vertebra (C2- the axis is the second vertebra of the spine) fracture and posterior vertebral body fracture with extension to the bilateral C2 pedicles (the short portion of bone connecting the posterior elements with the vertebral body), minimally displaced left C2 transverse process fracture (a break in one or more of the wing-like bones on the right and left side of each vertebra in the spine.) CT of thoracic spine shows nondisplaced right T1 (the first of	S9999		

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twelve vertebrae of the thoracic spinal column) transverse process fracture (type of spinal fracture). Scalp laceration, nasal bone fracture, and bilateral subsegmental PE (Pulmonary Embolism) without shortness of breath clinically. It also documents R2 has a past medical/surgical history of Prior left subdural hemorrhage (Status Post (s/p) left decompressive hemicraniotomy (a brain surgery that removes a portion of the skull) on 12/11/21 and 12/13/21, Cranioplasty (a surgical operation on the repairing of cranial defects caused by previous injuries or operations, such as decompressive craniectomy) on 02/11/22).

On 12/01/22 at 12:10 PM, V3 stated she was in the van when the incident happened with R2. V3 said she wasn't the staff member who secured R2 into the van on the day of the incident, she secured R1 in the van. R1 was sitting in the seat and had a seatbelt that went across her, R2 had a seatbelt that was across her lap. V3 stated they were leaving a store in a nearby town when the light changed and V4 suddenly stopped. V3 stated R2 went over her seatbelt and out of her chair. V3 stated she never looked or paid attention to R2's seatbelt prior to them leaving the store.

On 12/01/22 at 12:20 PM, R1 said V4 went to make a left-hand turn and when she did R2 flew out of the wheelchair. R1 stated when R2 fell out of her wheelchair she hit her head on the metal hardware on the floor that is used to buckle in another wheelchair. R1 said R2 had a big gash on her forehead and R2's nose was bleeding.

On 12/01/22 at 2:02 PM, V4 stated she was driving back from an appointment, when the stop light turned yellow, she said applied the brakes,

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S9999	Continued From page 5 the van didn't feel like it was going to stop, so she pushed a little harder to stop, and when she turned around to check on the residents, R2 was on the floor of the van. On 12/06/22 at 10:11 AM, V1 stated after the incident she (V1) and V8 (the maintenance man) recreated the entire incident of what happened on that day. She said she made V4 take her out to the van and show her (V1) exactly how she (V4) secured R2 in the van. On 12/06/22 at 11:50 AM, V1 (Administrator) stated V4 told her that R1 wanted R2 to sit right next to her in the van. V1 said that is not possible to do correctly. V1 said there are two stations for the wheelchairs to go. V1 said you can place a wheelchair in station 1 and secure the wheelchair by using the hooks that are located on the track up front and secure the back of the wheelchair by using the hooks that are in the middle of the van and you would use the lap seatbelt that is in the middle of the van. V1 said if you use the second station you would secure the front of the wheelchair by using the second set of hooks on the middle track and you would use the hooks at the back of the van to secure the back of the wheelchair and use the lap seatbelt that is in the back of the van. So V1 had V4 recreate the incident using herself (V1) in place of R2. V1 said V4 positioned her (V1) on the second set of tracks (which is located in between wheelchair station one and wheelchair station two). V4 used the hooks from the first set of tracks to secure the front of the wheelchair, and the hooks from the back set of tracks to secure the back of the wheelchair which made the wheelchair secure. Then V1 said when V4 placed the lap seatbelt on her (V1) she used the seatbelt that was located on the second (or middle) set of tracks and that	S9999		

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made the lap seatbelt have too much slack. V1 said with the seatbelt in this position she was able to throw herself out of the wheelchair. V1 stated when she was placed in the van correctly and secured correctly, she was unable to get out of the wheelchair.

On 12/06/22 at 11:00 AM, V1 said she would expect the staff that are transporting to use the proper labeled equipment for the station to secure the resident in the van.

On 12/06/22 at 11:05 AM, V8 (the maintenance man) stated V4 showed V1 and himself how she buckled R2 in her wheelchair the day of the incident. V8 stated the way V4 showed them (V1 and V8), V4 had buckled R2 half in one wheelchair station and half in the other wheelchair station. V8 said the chair was secured but the lap belt would have been down further on her thighs/knees, which wouldn't prevent the body from traveling. V8 said based on what V4 had told him on how she secured R2 in the chair the lap belt was to slack and not secured properly on R2's hip bone.

V4's Driver's license documentation was reviewed on 12/05/22 at 10:45 AM, and documents V4's driver's license expired on 05/29/22.

On 12/05/22 at 10:20 AM, V4 stated she did get her driver's license renewed but she was late in doing that. She said the facility doesn't have a copy of her new license.

On 12/06/22 at 10:50 AM, V1 (Administrator) stated she did not know V4's driver's license had expired until in November, the day after the incident with R2. V1 stated V4 came to her and

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S9999	Continued From page 7 said she needed to bring V1 a copy of her new license. On 12/06/22 at 2:30 PM, V1 said this incident could have been avoided if R2 had been secured in the van correctly. The Facility Van Usage Policy and Procedure, no date noted, documents "Purpose: The purpose of this policy is to establish procedures by which employees formally acknowledge and accept responsibilities of operating a Facility owned van on behalf of Petersen Health Care. Further, it establishes requirements for enforcement of operating procedures and safe driving practices. Policy: When employees operate a facility owned van, they have inherent responsibilities to care for the vehicle and residents, obey all state and local traffic laws, and abide by established driver operating procedures. This policy is designed to ensure that employees authorized to operate vehicles for the purpose of conducting business and transporting residents for the company will comply with certain conditions. Procedure: To ensure proper van usage: 1 Maintenance measures will be followed:" It further documents "b. Maintenance checks using the Vehicle Maintenance Check List. 2 Before operating a facility owned van, employees should obtain adequate authorization and comply with the requirements of an authorized employee. a. Possess valid driver's license" It further documents "e. Complete required van training in-services" The policy also documents "3 Employees must practice safe driving procedures and obey the rules of the road when operating a facility owned van." It further documents "b. Wear seat belts anytime the vehicle is in motion and require all passengers to wear seatbelts. C. Ensure all residents and wheelchairs are safely	S9999		

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