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LOFT REHAB OF DECATUR	500 WEST MCKINLEY AVENUE DECATUR, IL 62526

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S 000	Initial Comments Investigation to Facility Reported Incident of 1-9-23/IL155231 Complaint Investigations 22610341/IL154813 2260255/IL155202 2360297/IL155249	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b)4)5) 300.1210c) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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. Restorative measures shall include, at a minimum, the following procedures: 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.	S9999		

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S9999	Continued From page 2 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. These requirements were not met as evidenced by: These Failures require more than one deficient practice statement. A. Based on interview and record review the facility failed to provide properly functioning anchorage equipment in a facility transportation vehicle and failed to properly secure a residents wheelchair in a transportation vehicle, resulting in R2's wheelchair tipping over backwards during transportation, causing R2 to strike head, resulting in an Emergency Room visit due to a posterior head laceration requiring 5 staples. (R2) was one of three residents reviewed for accidents on the total sample list of eight. B. Based on observation, interview and record review the facility failed to implement fall prevention measures and failed to thoroughly investigate whether fall prevention measures were in place for two separate fall occurrences for one of three residents (R1) reviewed for accidents on the total sample list of eight.	S9999		

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S9999	Continued From page 3 Findings include: The facility's policy, with a revision date of 12/6/22, titled "Incidents and Accidents" documents, Policy: It is the policy of this facility for staff to utilize PCC/Risk Management to report, investigate, and review any accidents or incidents that occur or allegedly occur, on facility property and may involve or allegedly involve a resident. Definitions: Accident- refers to any unexpected or unintentional incident, which results or may result in injury or illness to a resident. Policy explanation: The purpose of incident reporting can include: Assuring that appropriate and immediate interventions are implemented and corrective actions are taken to prevent recurrences and improve the management of resident care." a 1.) R2's progress notes document on 1/9/2023 at 8:40 AM, staff reported that patient had tipped backwards during transport patient bleeding from laceration in back of head, transported to Emergency Department. R2's post fall observation note dated 1/9/23 documents, "Location of fall: outside of facility grounds, Detailed description of fall: fell backwards on facility van, Potential factors that could have contributed to fall: wheelchair security in van." R2's Fall IDT (interdisciplinary team) note documents, "Time of fall: 9:25 AM, Date of fall: 1/9/2023. Location of fall & position found: Resident was laying on her back in her wheelchair on the floor of the van. Unwitnessed. Activity at time of fall: Resident was being transferred to (Physician) appointment. Description of injuries/pain: Resident had a	S9999		

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laceration on the back of her head, was transferred to Emergency Room. Root Cause: when the driver turned, the wheelchair tipped causing resident and the wheel chair to tip over. Description of actions/interventions taken: Resident was assessed immediately after the event, was then taken to the Emergency Room for treatment. Intervention: driver to have safety awareness training while driving and to be re-educated on driving both facility vans."

The facility's fall investigation report file documents, "R2 was being transported back to facility from an appointment, wheelchair tipped backwards causing resident to fall backwards and hit her head on the floor of the van."

Statement of witness form completed by V6 Transport Driver documents, "Date 1-9-23, I unlocked the ramp and loaded resident as usual, locked both wheels and used all 4 straps to strap down wheelchair. We proceeded to head to towards (stop light), once the light turned green I proceeded to go that's when I heard (R2) holler, I turned into the closest parking lot to check (R2) out, (R2) told me she was okay but hit her head, she demanded me to take her to the Emergency room."

Statement of witness form signed by R2 documents, on 1-9-23 "(V6) pushed me onto the van and buckled my wheelchair, took a couple turns and I felt my wheelchair falling in slow motion, I tried to grab onto something but their was nothing to hold on to. My chair fell backward I hit my head on the ramp thing I reached up to touch my head to block it and I felt my head was bleeding (V6) pulled over to check on me. I asked (V6) for something to put on my head, (V6) gave me some towels then (V6) called the

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S9999	Continued From page 5 hospital and (V6) took me there." R2's Emergency Room after visit summary documents "Reason for visit: Fall, Diagnosis: Laceration to scalp. Emergency Department triage note, date of service: 1/9/23 at 8:58 AM, "Patient here from (nursing home) by van when the wheelchair tipped over backwards, had to assist the chair back up. Patient has laceration to the back of head and is complaining of neck and mid upper back pain. C-Collar applied. Bleeding controlled to her head." R2's progress notes document on 1/9/2023 at 12:20 PM, "return to facility 5 staples to laceration, order to keep area clean and dry." R2's Skin Observation Tool form dated 1/9/23 documents, "Site: back of head, Type: Laceration, approximately 5 staples." On 1/11/23 at 11:20 AM, V6 (Transport Driver) stated, "on 1/9/23 (R2) had an appointment at 8:45 AM, our facility van was in the shop so I was using the van from next door. It was the first time ever using that van, instead of loading chairs in from the rear of the van, you load them from the side. I got the ramp down, pushed (R2) onto the ramp, locked the wheels and secured the straps (tie-downs) to (R2's) wheelchair using four straps. I had (R2's) wheelchair facing the left side of the van and (R2's) back was to the right side of the van (sideways in the van). Two of the floor straps did have some give in them (the front left and back right), I tried to tighten them the best I could, I thought they felt secure. I had secured (R2's) chair by placing the two front floor anchor straps (tie-downs) through the back of the wheel spokes, one on each side and the rear anchor straps (tie downs) were secured to (R2's) cross	S9999		

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bars on the rear of the wheelchair. The lap belt in that particular van was not working properly, so I did not have a lap belt on (R2). I left the facility parking lot and pulled up to the stop light, went to turn left and (R2's) wheelchair tipped backwards, (R2) had hit head on the loading ramp. I heard (R2) holler, I immediately pulled over, assessed (R2), (R2) requested to go the Emergency Room, I called the facility, left (R2) in that position, and took (R2) to Emergency Room, staff there helped get (R2) up. I took the van straight to V8 (transport driver) and asked what I did wrong because I could not figure it out, we looked at it and determined the straps were not tightening down (locking in place).

On 1/11/23 at 1:30 PM, V8 (Transport Driver) stated the lap belt works in the van, the issue was (V6) had (R2) facing the wrong direction. V3 (maintenance) replaced the anchors in this van yesterday, they were old and sometimes the latching mechanism would not work properly, preventing the belt from locking, instead was sliding out."

On 1/11/23 at 11:20 AM, V3 Maintenance stated, "I was notified to the (floor anchors/tie down straps) were needing replaced in the transport van, I replaced the straps on 1/10/23. The straps I took off had no rips or tears, there were just "dated"."

On 1/11/23 at 11:00 AM, V1 Administrator stated, "On 1/9/23 (V6) Transport Driver was using the transport van from next door, (V6) wheeled (R2) into the van and buckled (R2's) wheelchair straps to the floor placing 4 straps across the rims of the wheelchair. (V6) pulled out of the facility parking lot to the stop light and went to turn, I believe left and when turned heard a noise and heard (R2)

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holler out, (V6) turned into the nearest parking lot and went back to assist (R2). (R2) was laying backwards wheelchair had tipped backwards, (R2) had hit head and wanted to stay in that position and requested to go to the emergency room. (R2) went to the Emergency Room, had laceration to head and received staples. Straps in that van needed replaced and education was given to (V6) to ensure equipment is functioning properly. (V6) had stated she had noticed the straps had some give to them when she fastened them and tried to tighten them up.

The corporations undated "Facility transport van safety checklist and rules, "documents: 16. Secure wheelchair (front and back) with straps on floor of van: secure straps to back and front frame of wheelchair. 17. To tighten straps push red button at base of strap then hand tighten with know. 18. Attach lap belt to back ratchet strap, crossing strap across resident' slap, attach shoulder belt across residents shoulder/chest. 19. Check to ensure all straps are locked down on wheelchair tightly, seat lets are properly in place. Also double check the wheelchair brakes are locked and secured from movement."

Q'Straint User instructions manual documents, "A- Secure Wheelchair. 1- Place wheelchair facing forward in securement area, apply wheel locks or turn power off. 2. Attach tie downs into floor anchorages and ensure they are locked in. 3- Attach the four tie-down hooks to (wheelchair) solid frame members or weldments, near seat level. Ensure tie-downs are fixed at approximately 45 degrees, and are within angles shown on figure 2 (between a 40 to 60 degree angle on the front wheelchair frame). Do not attach hooks to the wheels, plastic or removable parts of wheelchair. 4. Ensure all tie-downs are

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locked and properly tensioned. If necessary, rock wheelchair back and forth or manually tension retractor knobs to take up additional webbing slack."

Inservice education report completed by V7 Transport driver instructor, dated 1/9/23 and documents "Content: Safety Awareness while driving training, re-education on driving transportation vans" was completed with V6 Transport Driver.

b 1.) R1's medical record documents an admission date of 10/18/2022. R1's admission diagnosis include: History of falls.

R1's care plan, with a start date of 10/18/22, documents, "Focus: I am at risk for falling related to generalized weakness, poor standing balance, history stroke with left side weakness, asthma, history of falls, anemia, peripheral vascular disease, start date: 10/18/22. Interventions: (1/2/23-fall) Scoop mattress, (12/19/22 - fall) Body Pillow, (12/30/22-fall) mattresses on floor, (12/7/2022 fall)- Staff to increase room checks and to ensure toileting needs are met. Assure I am wearing my eyeglasses daily. Assure they are clean and in good repair (10/18/22). Keep call light within reach at all times (10/18/22). Keep personal items and frequently used items within reach (10/18/22)."

R1's progress notes document on 12/19/2022 at 6:10 AM, resident observed lying on floor next to bed on right side. R1's Fall IDT (interdisciplinary team) note documents, "unwitnessed fall, Root cause: resident has a twin bed and while (R1) sleeps, (R1) rolls to the side and this time when (R1) rolled, (R1) fell onto the mats next to (R1's) bed. Interventions: include a body pillow while

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S9999	Continued From page 9 (R1) is in bed sleeping." R1's progress notes document on 12/30/2022 at 2:10 AM, "Witness: no, Location: resident was observed on floor, lying on right side, beside (R1's) bed, in (R1's) room." R1's Fall IDT note documents, Unwitnessed fall, Root cause: resident has been really restless at night lately, rolling around in bed. When (R1) does this (R1) rolls off the side of the bed onto the floor. Intervention: (R1) is to have two mattresses on both sides of (R1's) bed." R1's Post Fall observation form dated 12/30/22 documents, "Location of fall: residents room, Detailed description of fall: resident was lying on floor, on the right side, beside bed, in room. Footware: bear feet. Were any measures in use at the time of the fall, "none" is documented." R1's progress notes document on 1/2/2023 "resident fell by bedside from bed, acquired skin tears bilateral upper extremities." R1's Fall IDT note documents, "Time of fall: 11:15 AM, Unwitnessed, Root Cause: when resident sleeps (R1) tends to roll from side to side in the bed, when rolls tends to roll out of the bed. Intervention: (R1) to have a scoop mattress for (R1) to be able to define the parameters on (R1's) mattress." R1's Post Fall observation form dated 1/2/23 documents, "Witness: no, Location: resident room, resident found by aid laying on the mat beside (R1's) bed, bed was in low position, fall mats were beside the bed, Were any measures in use at the time of the fall: low bed, fall mats." R1's medical record and facility investigation notes did not document whether R1 had a body	S9999		

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S9999	Continued From page 10 pillow (fall prevention measure) in use at the time of the fall occurrences on 12/30/22 at 2:10 AM and 1/2/23 at 11:15 AM. On 1/17/23 at 11:50 AM, R1 was lying in bed with scoop mattress on bed, bilateral fall prevention mats on each side of the bed, body pillow to the right of R1, bed was in low position. There was a push pad call light on the floor at the head of the bed, under the bed frame. V16 Certified Nursing Assistant came in R1's room and confirmed R1's call light was on the floor under the head of the bed, V16 stated, "(R1) gets to moving around in the bed and may have knocked it off or it may not have been clipped on the bed very well. V16 picked up the call light and placed it in reach for R1, V16 stated, "(R1) is alert and able to use the call light and tell you everything (R1) wants." On 1/17/23 at 9:00 AM, V2 Director of Nursing stated, "I am new to doing the fall investigations, I don't document everything through interviews on paper, it is just scratch paper. I believe R1 had a body pillow when R1 fell out of bed on 12/30/22." On 1/17/23 at 2:45 PM, V1 Administrator confirmed R1's fall interventions include: body pillow and call light to be in reach. (B)	S9999		