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S 000	Initial Comments Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 300.2420j) 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 nursing	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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 300.2420 Equipment and Supplies j) There shall be a sufficient quantity of resident care equipment of satisfactory design and in good condition to carry out established resident care procedures. This shall include at a minimum the following: wheelchairs with brakes, walkers, metal bedside rails, bedpans, urinals, emesis basins, wash basins, footstools, metal commodes, over the lap tables, foot cradles, footboards, under the mattress bed boards, trapeze frames, transfer boards, parallel bars and reciprocal pulleys. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a resident was properly secured during a vehicle transport while sitting in a wheelchair, failed to ensure a resident had a properly fitting wheelchair for safe positioning, failed to assess a resident with potential for injury after sliding off the wheelchair prior to moving them, and failed to immediately report the accident to facility administration for one of three residents (R14) reviewed for accident hazards on the sample list of 26. This failure resulted in R14 sliding forward, halfway falling out of the wheelchair and hitting R14's leg on the elevated van stoop/ledge and back of the	S9999		

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driver's seat, resulting in a right sided fractured patella and femur, a suspected lateral clavicular fracture, and a suggested comminuted proximal fracture of the fibula.

Findings Include:

On 4/02/23 at 8:11 AM, R14 was lying in bed with a full leg cast on the right leg, and a wheelchair in the corner of R14's room with two four-inch cushions and one one-inch cushion on the wheelchair seat with a sign on the back of the wheelchair that read, "Do not use this wheelchair or cushions." R14 stated R14 broke R14's kneecap and leg after having an accident in the facility van. R14 stated a vehicle in front of the facility van was backing up in front of them so V7 (Maintenance/Transportation) had to hit the brakes and swerve to avoid hitting the vehicle but in the process of that, R14 was "thrown forward". R14 stated R14 never fully left/fell out of R14's wheelchair because R14 was secured in the wheelchair with the belt around R14's waist, but the force pushed R14 forward in the chair. R14 stated V7 and V5 (Certified Nursing Assistant/CNA), who was also in the van, immediately unlocked R14's breaks to scoot R14 back into the wheelchair. R14 stated that after arriving back to the facility, R14 was sent to the hospital and ended up being there a few days due to R14 having the fractures.

The facility Report to IDPH (Illinois Department of Public Health) dated 3/22/23 documents an accident occurred on 3/15/23 at 2:10 pm where R14 was in a motor vehicle accident and slid forward in the wheelchair and sustained a questionable right leg injury. R14 was

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transported to the hospital for evaluation and treatment. While hospitalized, R14 was diagnosed with an "acute traumatic mildly displaced distal right femoral metaphysis fracture, distracted avulsion fracture inferior right patella, and a suspected lateral right clavicular fracture." Based on the comprehensive investigation, the facility determined on 3/15/23, R14 was transported in the facility van from a medical appointment back to the facility when the van driver was forced to brake suddenly to avoid an accident. R14 complained of pain to the right leg when R14 returned to the facility.

The facility's investigation into R14's 3/15/23 accident contained witness statements from V5 (CNA) and V7 (Maintenance/Transportation), both who were present and in the van with R14 at the time of the accident.

V5's witness statement documents at approximately 2:10 pm V5, V7 and R14 were driving southbound when a black pickup truck pulled out in front of them and V7, the van driver, braked extremely hard and swerved left to avoid hitting the truck while V5 put V5's left hand back to try to pretty much hold R14 back. The statement documents V5 was able to touch R14's knees but was unable to hold R14 completely back {in R14's wheelchair}and R14 slid onto the floor of the van resting on R14's right side with R14's knees bent. The statement documents V5 and V7 pulled over right away, opened both doors, sat R14 up and assisted R14 back into the wheelchair and at that time, V5 looked R14 over and noticed R14 had a small abrasion and bruise on R14's right shin and R14 complained of pain to both knees, the right hip, and shoulders. The statement documents V5 and V7 came to facility and V5 notified V2 (Director of Nursing/DON) of

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S9999	Continued From page 4 the incident who then completed an assessment of R14 and sent R14 to the hospital. V7's witness statement documents at approximately 2:10 pm, V7 was headed southbound {in the van} when a black pickup truck pulled left into V7's lane and immediately stopped causing V7 to have to brake hard to avoid a collision, stopping approximately 2-3 inches from the pickup's bumper. The statement documents R14 was secured as usual, the floor anchors were secured, and the wheelchair was secured. The statement documents the seatbelt was across the lap of the resident and secured to the pin on the floor of the van. The statement documents the shoulder strap hooks to the lap seat belt but became unhooked from the lap seat belt. The statement documents V7 and V5 placed R14 back into the wheelchair, secured it, and returned to the facility and notified the DON immediately. This investigation also contained diagnostic imaging results dated 3/15/23 that document the following: 1.) suggested comminuted proximal diaphyseal fracture of the fibula. 2.) appears to be an acute fracture through the inferior 3rd patella with 6 mm (millimeter) distraction. There is additionally irregularity of the superior patellar margin possible avulsion injury. There is intra-articular fracture through the distal femoral metaphysis and epiphysis, possibly comminuted. Also, possibly chronic appearing deformity of the proximal shaft of the fibula. 3.) suspected lateral clavicular fracture with severe underlying shoulder internal derangement. R14's MDS (Minimum Data Set) dated 1/28/23 documents R14 is able to understand others and	S9999		

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S9999	Continued From page 5 make R14's self-understood. R14's ongoing personal information documents R14 is 63 inches tall and weighs 104 pounds as of March 2023. R14's Fall Risk Assessment dated 1/25/23 documents R14 is at risk for falls. R14's Progress Notes document the following: 3/15/23 - does not document R14's near vehicle accident and sliding forward partially out of the wheelchair but does document R14 was sent to the hospital with complaints of pain and new skin concerns: bruising/abrasion/scratch to the right knee, bruising to the right lower leg with a small abrasion, bruising to the left leg. 3/16/23 - called hospital to get an update on R14, the nurse reported R14 has a broken right femur, kneecap, and clavicle. 3/19/23 - Report from {hospital} nurse received and R14 is alert and oriented x 4, had a closed reduction of the leg, and is to use a Lidocaine patch to the fractured clavicle. R14 returned to facility via ambulance. On 4/02/23 at 2:57 PM, V1 (Administrator) stated when V5, V7, and R14 returned to the facility, V7 was so upset, V7 was in tears. V1 stated V1 had V7 re-enact the situation with V1 and come to find out, whenever R14 travels, R14 sits on three cushions so R14 can sit up tall and see, due to being so petite. When V7 hit the brakes, the shoulder strap came undone, R14 then went under the lap belt due to the three cushions sliding out from under R14. Therapy evaluated R14 for the cushions and type of wheelchair and R14 no longer uses those cushions or that wheelchair. V1 stated the root cause of R14 coming out of R14's wheelchair was the	S9999		

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S9999	Continued From page 6 unsecured cushions. On 4/03/23 at 1:15 PM, R14 was lying in bed with V16 (CNA) and V8 (Licensed Practical Nurse/Wound Nurse) in the room. At this time, R14 stated, "I (R14) have a good memory and I (R14) did not fall out of the wheelchair. I (R14) was sitting in the middle of the van, between the driver and CNA and when the truck pulled in front of us and we pulled over to the side of the road, I (R14) slid to the front of the wheelchair, but I (R14) was still buckled. That was part of the problem, my legs were up against the back of the seats, and I (R14) couldn't go anywhere because it {wheelchair} was tied down and my legs had nowhere to go other than up and that is how it broke." R14 again stated R14 was buckled around R14's waist only. R14 also confirmed the wheelchair in the corner with the do not use sign on it is the wheelchair R14 was in during the accident and that R14 was sitting on the three cushions in the wheelchair at the time of accident. R14 explained that R14's legs are so long, sitting on the three cushions is the only way R14 can sit comfortably in the wheelchair. R14 stated R14 use to have a different wheelchair but it kept breaking and needing repaired so after R173 passed away, the facility gave R14, R173's wheelchair to use. R14 stated the facility knew R14 needed a taller wheelchair but they didn't have any. R14 explained some of the CNAs check to make sure the cushions are all the way back in the wheelchair seat but R14 doesn't know if V5 did that day or not. R173's medical record documents R173 passed away on 1/3/23. On 4/03/23 at 2:54 PM, V2 (DON) stated R14 was coming home from a doctor's appointment	S9999		

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and a car pulled out in front of them so V7 swerved and slammed on the breaks. V2 is not sure if R14 came out of the wheelchair or not but V2 knows there was talk of the wheelchair moving when V7 had to slam on brakes and swerve and wondering if during that process of the wheelchair moving forward and back again that the safety belt came unhooked but V2 "don't really know. I know (R14) injured (R14's) knee, femur and shoulder due to the impact but again, don't know what the impact was on." V2 explained V2 was not aware that R14 used all 3 cushions when in the wheelchair until the incident. V2 does not know if R14 was evaluated for proper seating/positioning in the wheelchair when R14 was originally given it, sometime after 1/3/23, but stated since the accident, R14 was evaluated by OT (Occupational Therapy) and no longer uses that same wheelchair or cushions.

On 4/03/23 at 3:13 PM, V5 (CNA) confirmed V5's written statement was accurate. V5 stated on the way back from R14's physician appointment, a black pickup pulled in front of the van R14, V5, and V7 were riding in. V7 braked and swerved to prevent from hitting the truck. V5 stated V5, who was in the passenger seat, immediately put V5's hand back {to where R14 was sitting in the wheelchair} to try and prevent R14 from moving forward and was able to touch R14's knees but V5 wasn't able to hold R14 back. V5 explained R14 had been secured in the wheelchair by the wheelchair brakes being locked, the wheelchair being secured to the van floor with the hooks and R14 being buckled in, with a lap belt only, but R14 still moved. V5 stated V5 had been instructed by V22 (Maintenance) that R14 was only to use the lap belt, and not the shoulder strap because it can choke R14. V5 stated the seat buckle, came loose somehow and R14 slid

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down out of the wheelchair explaining R14's buttocks was half on the wheelchair seat and half on the little step/ledge that the wheelchair pedals go over, slightly on R14's right side with R14's legs bent and facing to the left. V5 stated R14's right knee was touching the back of the driver's side seat and R14's upper body was behind the passenger seat. V5 stated the sheep skin cushion that R14 had been sitting on came out of the wheelchair and was on the ground and the two four-inch cushions stayed in the wheelchair but moved to behind R14 due to them not being secured or tied to the wheelchair. V5 stated V7 immediately pulled over and they got R14 up, back into the wheelchair, due to R14 complaining of R14's knee hurting. V5 explained, R14's knees don't normally bend the way they were so V5 thought the discomfort was just from the way they were bent so we wanted to get R14 up and situated. After getting R14 resecured in the wheelchair, we headed back to the facility, and a couple of miles down the road, R14 started to complain of R14's right knee hurting again and wanting to put R14's leg on the ground and off of the foot pedal. V5 stated V5 moved R14's leg for R14 and that relieved some of the pressure in the knee, so they continued to travel back to the facility, approximately 20 minutes away. V5 stated by the time R14 was almost back to the facility, R14 started saying that R14 couldn't move R14's right leg at all and wasn't able to feel R14's right leg. V5 stated when R14 returned to the facility, V2 (DON) was the nurse working the unit so V2 assessed R14 and sent R14 to the hospital. V5 stated V1 (Administrator) then in-serviced V5 and V7 to call 911 in a scenario like this, where a resident might be hurt, instead of moving the resident like V5 did.

On 4/04/23 at 8:50 AM, the facility transport van

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S9999	Continued From page 9 was observed with V7 and V1 present. The van has a back ramp that the wheelchair rolls into with a 9-inch ledge/stoop that surrounds the wheelchair. Securement straps/hooks are in the van floor. V7 stated that after pushing R14's wheelchair into the van, V7 attached all 4 hooks to each corner of the wheelchair frame and then tightened them down so that the wheelchair could not move, then locked both wheelchair brakes, and then place the seat belt, which is also attached to the floor around R14. The seat belt consists of a lap belt with a shoulder strap that attaches to it with a hook and pin buckle (a piece of metal that goes into a hole in the other end of the buckle and slides into place). V7 stated the shoulder strap is always attached to the lap belt. V7 stated the day of R14's accident, R14 was secured in the wheelchair as described and V7 is "pretty sure" the shoulder strap was attached to the lap belt as V7 "never undid it" but that after V7 had to slam on the brakes and swerve, the shoulder strap was no longer on R14 and R14 buttocks were off of the wheelchair seat, knees resting on the 9 inch ledge and the 3 cushions R14 had been sitting on were up behind R14's back. R14 was complaining of knee pain at that time so V5 got R14 back into the wheelchair seat, and once R14 was secured again, we returned to the facility, which is approximately 12 miles away from the accident site. At this time, V1 stated R14 is alert and oriented and that with the differences in V5 and V7's details of the accident, R14 would be able to recall the accident. On 4/6/23 at 2:11 pm, V30 (Registered Nurse/RN) stated R14 does not have good hand dexterity. V30 stated R14 is not able to manipulate small objects and would not be able to unhook the transport seat belt.	S9999		

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On 4/04/23 at 9:15 AM, R14 was lying in bed and again stated at the time of the accident the wheelchair was secured to the floor in the front and back of the wheelchair, the brakes were locked and that R14 had a belt around R14 but did not have a shoulder strap on. When asked if R14 knew what a shoulder strap was, R14 stated, "I (R14) know what you are talking about because I (R14) remember seeing other people with a strap over their shoulder when in the van and I (R14) thought there must be something wrong with their upper body that they needed it because I (R14) had never used it."

On 4/04/23 at 9:30 AM, V21 (Certified Occupational Therapy Assistant/COTA) with V11 (Therapy Director) present stated V21 has never evaluated R14 for a wheelchair, before or after R14's accident on 3/15/23. At this time, V11 stated that an actual evaluation was not completed, however after the accident R14 was given a different wheelchair to use, one with elevating leg rests and one cushion instead of three. V11 stated V11 then instructed the CNAs that if R14 was not positioned good in the new wheelchair to let therapy know and they would get an evaluation completed by the OTR (Occupational Therapist - Registered). V21 stated using three cushions is not good for positioning and safety. "I (V21) would not recommend stacking the cushions but then again, (R14) isn't on my case load so I (V21) can't tell the nursing staff not to do that if that is what (R14) wanted."

On 4/04/23 at 9:45 AM V22 (Maintenance) with V20 (Maintenance Director) present confirmed V22 provided education to V5 (CNA) a month or two ago on how to secure residents in the van for transportation and instructed V5 to push the

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resident into the van, lock the wheel brakes, hook all 4 corners of the wheelchair to the straps in the floor and secure the lap/shoulder strap, which is an all-in-one safety belt. V22 stated V22 doesn't remember ever telling V5 to not use the shoulder strap due to the risk of choking a resident but might have said make sure you aren't choking them but "I (V22) never said not to use it." At this time, V20 stated V20 doesn't know how the shoulder belt could have come unhooked and confirmed when the inspector checked the van and securement devices out, they didn't find anything wrong/malfunctioning on the strap.

On 4/04/23 at 11:49 AM, V25 (Van Inspector) stated V25 inspected all the straps and locking components in the van after the incident and did not see a problem with any of them. V25 also stated if the facility is claiming the chest strap came unsecured from the lap strap, it was probably because it was not hooked up correctly, because all the securement straps passed the pull test.

On 4/04/23 at 12:01 PM, V27 (Nurse Practitioner) stated if R14 was complaining the wheelchair that the facility provided to R14 did not fit R14 correctly, and R14 was needing to sit on three pillows to be comfortable, R14 should have been evaluated for a different wheelchair. V27 reported that R14 told V27 that R14 was secured with a belt so V27 assumed it was like in a car, with a lap and shoulder belt and explained if it wasn't on, that would make more sense as to how R14 was able to move forward in the wheelchair. V27 explained, the safety belt would no longer be tight after the three pillows (measuring 9 inches tall) were no longer under R14, and that would have allowed enough space for R14 to slide out of the wheelchair, under the

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(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 12	S9999		

waist strap because R14 is so tiny, and the strap would no longer be tight then. V27 stated V5 and V7 should have never moved R14 with R14 complaining of pain, "they should have called EMS (Emergency Medical Services) at that point instead of bringing R14 back to the facility."

The undated User Instructions for securing a resident in the transportation van documents to first secure the wheelchair by placing the wheelchair facing forward, apply wheel locks, attach the tie downs to the floor anchors, attach the four tie down hooks to the solid frame of the wheelchair, and ensure all tie downs are locked and properly tensioned. After the wheelchair is secured, then you secure the passenger by attaching the lap belts between the seat back and bottom and/or armrest to ensure proper fit around the occupant then attach the shoulder belt by extending the shoulder belt over the passenger's shoulder and across the upper torso and fasten the pin connector onto the lap belt. Ensure belts are adjusted as firmly as possible, but consistent with user comfort.

The facility Fall Prevention Program dated May 2022 documents this program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized, as necessary. The fall prevention program includes the following components: methods to identify risk factors, methods to identify residents at risk, educate resident and resident representative to fall prevention program at time of admission/throughout residents stay/and when changes occur, use and implementation of professional standards of practice, adherence to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000012	A. BUILDING: _____ B. WING _____	04/10/2023

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S9999	Continued From page 13 manufacturer's recommendation in use of alarm/medical devices/special care equipment. Safety interventions will be implemented for each resident identified at risk. The Director of Nursing or Designee is responsible for monitoring the Fall Prevention Program, including further staff education programs, purchase of additional equipment, or other appropriate environmental alterations. Each resident will be screened by a specialist therapist at the time of admission, quarterly, and after each fall, as appropriate, and with significant change in the resident's mental and functional abilities. "A"	S9999		