STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005441	A. BUILDING: _____ B. WING _____	C 04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINCKNEYVILLE NURSING & REHAB	708 VIRGINIA COURT PINCKNEYVILLE, IL 62274

(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 Investigation of Facility Reported Incident of 3/31/23/IL158696	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 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 b) The facility shall provide the necessary care and services to attain or maintain the highest	S9999	**Attachment A** **Statement of Licensure Violations**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005441	A. BUILDING: _____ B. WING _____	C 04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINCKNEYVILLE NURSING & REHAB	708 VIRGINIA COURT PINCKNEYVILLE, IL 62274

(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 1 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: Based on interview and record review, the facility failed to safely transport a resident in a wheelchair to prevent an accident for 1 of 3 residents (R1) reviewed for accidents in the sample of 6. This failure resulted in R1 sustaining a fall from R1's wheelchair that resulted in R1 receiving a laceration to left (side) forehead, left eye lid ecchymosis, left infraorbital skin tear, as well as some left forehead skin tears. The findings include: R1's undated Face sheet documents that R1 was	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005441	A. BUILDING: _____ B. WING _____	C 04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINCKNEYVILLE NURSING & REHAB	708 VIRGINIA COURT PINCKNEYVILLE, IL 62274

(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 2 admitted to the facility on 12/1/22 with diagnoses including Parkinson's Disease, Alzheimer's Disease, unspecified dementia (unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety), abnormal posture, muscle weakness, history of falling, and other lack of coordination. R1's MDS (Minimum Data Set) dated 2/24/23 documents that R1 has a BIMS (Brief Interview of Mental Status) of 04 which indicates that R1 has severe cognitive impairment. The same MDS documents under Section GG that R1 uses a wheelchair for mobility. Section GG also notes that R1 requires partial/moderate assistance to wheel 50 feet with two turns and partial/moderate assistance to wheel 150 feet. R1's "Physical Therapy Plan of Care" dated 2/17/23 documents the reason for referral as "recent diagnosis of Urinary Tract Infection (UTI) and falls." Under the section titled "Initial Assessment" it documents that R1 has a functional deficit of mobility with the use of a wheelchair (WC)/ scooter: wheel 50 feet with 2 turns and R1's current level of functioning as "Partial/moderate assistance, helper lifts, holds or supports trunk or limbs, but provides less than half the effort." R1's facility Incident Report to the Illinois Department of Public Health (IDPH) dated 3/31/23 labeled "Initial Report" and "Final Report" documents under the section "Initial Status" that "on 3/31/23 at approx. (approximately) 9:00 AM while at the hospital, Certified Nurse's Aide (CNA) was pushing resident in wheelchair when wheelchair wheels came into contact with the 'American's with Disabilities Act (ADA) truncated surface tile' causing the wheelchair to tip forward	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005441	A. BUILDING: _____ B. WING _____	C 04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINCKNEYVILLE NURSING & REHAB	708 VIRGINIA COURT PINCKNEYVILLE, IL 62274

(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 3 and resident to fall out of wheelchair. Hospital staff was alerted, and resident was immediately taken to the Emergency Room (ER) at (name of hospital) for evaluation and treatment." The report further documents that "report received from (hospital staff member) at (name of hospital) at approx. 1:15 pm stating resident received 5 sutures to head wound. Computed Tomography (CT) of head and neck negative." The same report documents under the section "Conclusion" that "All staff will be educated on either going around the ADA Truncated surface tiles or turning the wheelchair around and going in reverse over the tiles when encountered. R1 will have front anti-tippers applied to her wheelchair." R1's Emergency Room Physician Chart, dated 3/31/23, documents under "additional information" that a "medical emergency called patient (PT) on ground outside fell out of wheelchair (W/C) while being pushed into hospital for appointment." The Emergency Room Physician chart further documents under "Physical Exam" that R1 had a laceration on left (side) of forehead measuring 4.5cm (centimeters). R1 also had left eye lid ecchymosis, left infraorbital skin tear as well as some left forehead skin tears. The same document under "Procedure" that a repair of the laceration was completed using a one-layer closure. Length of the laceration repair was 4.5 cm, was closed with 4-0 nylon (sutures). R1's Care Plan documents a Care Plan category of fall and a history of falling with a start date of 12/2/22 with documented interventions of remind to ask staff for assistance with ambulation, assist of 1 staff member for ambulation, and monitor for changes in condition that may warrant increased supervision/assistance, notify physician. R1's	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005441	A. BUILDING: _____ B. WING _____	C 04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINCKNEYVILLE NURSING & REHAB	708 VIRGINIA COURT PINCKNEYVILLE, IL 62274

(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 4 Care Plan documents an intervention dated 1/19/23 of "resident wheelchair will be placed close to resident as a visual clue to have resident ask for assistance." R1's Care Plan also documents a Care Plan category of "Fall from W/C while being transported to an appointment" with a start date of 3/31/23. Interventions documented include monitor bruising on R1's face and report to physician as needed, when transporting resident pull resident from behind when going over a bump, in-service to train staff on proper transportation of resident. The same care plan notes an intervention with a start date of 4/1/23 for foot pedals to be used at all times during transport. On 4/18/23 at 9:45am, V1 (Administrator) said she completed the investigation on the incident on 3/31/23 involving R1 falling from her wheelchair when out of the facility going to an appointment. V1 said that R1 had an appointment at the hospital for a Doppler study. V3 (CNA/Certified Nurse Assistant) took her to the appointment. V1 said that V3 was pushing R1 in the wheelchair and hit the ADA (Americans with Disabilities Act) truncated surface tile and the wheels stopped causing R1 to fall out of the wheelchair. V1 said that R1's family was there when the incident occurred but is not sure if he witnessed the incident or not. V1 said that V3 was very upset over the incident. V1 said that R1 was taken into the emergency room at the hospital and received stitches and also had some bruising to her face. V1 said she is not sure if V3 had the footrests on the wheelchair or not. On 4/18/21 at 10:20am, V3 (CNA) said she was taking R1 to an appointment at the hospital. V3 said she parked in the handicap parking in the front of the parking lot. V3 said she made it to the	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005441	A. BUILDING: _____ B. WING _____	C 04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINCKNEYVILLE NURSING & REHAB	708 VIRGINIA COURT PINCKNEYVILLE, IL 62274

(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 5	S9999		

end of the sidewalk where there were "red things" for vision impaired. V3 said she hit the bumps with the wheelchair, and it made the wheelchair stop and R1 fell forward out of the chair. V3 said it happened so fast she could not catch (R1) from falling. V3 said that there was no way she could go around the red things due to the curbs. V3 was crying and said she does not know why she didn't put the footrests on the wheelchair. V3 said she knew to use them but just forgot. V3 said she came in just to take R1 to the appointment. V3 said the hospital staff got on her also for not using footrests on the wheelchair. V3 said the accident was like in slow motion and she couldn't stop it.

On 4/18/23 at 3:45pm, this surveyor went to the hospital location where R1's fall incident occurred. The particular sidewalk where the fall occurred was observed to connect the parking lot area to the roadway area where patient/transport vehicles drop off near the hospital entrance. This area of the sidewalk was noted to have a decline of approximately 4 - 6 inches with truncated ADA tiles at the end of the sidewalk just before the roadway.

Video surveillance footage provided by the hospital was reviewed. The surveillance footage dated 3/31/23 with a time stamp of 9:11 AM, shows V3 pushing R1 in a wheelchair on the sidewalk near the hospital entrance. As the wheelchair descended through the ADA truncated tiles onto the smooth roadway/ concrete surface, R1's left foot, followed by the right foot, are observed dropping and coming into contact with the concrete surface approximately 1 to 2 feet past the ADA truncated tile. R1 is then observed falling forward out of her wheelchair onto the concrete surface. There are no foot plates or foot rests observed on R1's wheelchair in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005441	A. BUILDING: _____ B. WING _____	C 04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINCKNEYVILLE NURSING & REHAB	708 VIRGINIA COURT PINCKNEYVILLE, IL 62274

(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 6 surveillance footage. On 4/18/23 at 10:40am, V5 (LPN/Licensed Practical Nurse) said she would expect staff to use a footrest when taking a resident out of the facility unless they are independent. On 4/18/21 at 10:50am, V4 (CNA/Certified Nurse Assistant) said if a resident does not really use their feet, she would use a footrest on the wheelchair when taking a resident out of the facility. On 4/18/23 at 10:45am, V6 (LPN/Licensed Practical Nurse) said she would expect that staff would use a footrest on the wheelchair when transporting a resident out of the facility. On 4/18/23 at 12:05pm, V8 (CNA/Certified Nurse Assistant) said that he would use footrests when he takes a resident out of the facility. On 4/18/23 at 2:15pm, V10 (family member of R1) said he volunteers and drives a golf cart around the parking lot of the local hospital. V10 said he was aware R1 had an appointment for a Doppler and went to where they parked. V10 said that the staff got R1 out of the back of the van and began pushing her on the sidewalk. V10 said he asked the staff if they needed any help, and they said no. V10 said he turned his head for a minute and when he looked back over, R1 had fallen forward out of the wheelchair and was bleeding. V10 said hospital staff came out and took her in for treatment. V10 said that from where they parked the car, it was maybe 50 feet to the entrance. V10 said there were bumps for the Disabilities Act and the wheels of the wheelchair like locked and she fell forward. V10 said that some days R1 is more with it and can	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005441	A. BUILDING: _____ B. WING _____	C 04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINCKNEYVILLE NURSING & REHAB	708 VIRGINIA COURT PINCKNEYVILLE, IL 62274

(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 7 tell you what she had for lunch, and then other times she cannot. V10 said that he and his brother had talked the evening after the accident about footrests on the wheelchair. V10 said he went to the facility the next day and talked with the Social Service person (V7) and told them he would like them to use footrests on her wheelchair. V10 said that R1 does not like them, and he told V7 that if they agitated R1, they could turn them to the side. V10 said he has been to the facility every day since the accident and the footrests have been on her wheelchair. On 4/19/23 at 10:06am, V13 (Emergency Room Director at local hospital) said that she and another nurse were on duty on 3/31/23 and went outside to where R1 was on the ground and assessed R1. V13 said they brought R1 on a gurney back into the ER (emergency room). V13 said that the staff with R1 was visibly upset and crying. V13 said that she noticed that staff did not have foot pedals on the wheelchair when pushing her. V13 said she talked to staff about using foot pedals when taking a resident out of the facility. V13 said that she told them how a resident's foot can drop and also cause an accident and to always use the footrest. Observations were made at various times during the day on 4/18/23, R1 was noted to have footrests on her wheelchair and did not appear to have anxiety about them being on her chair. Attempts to interview R1 were unsuccessful due to R1's impaired cognition. (B)	S9999		