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	IL6007439	A. BUILDING: _____ B. WING _____	C 07/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVE OF ST CHARLES	611 ALLEN LANE SAINT CHARLES, IL 60174

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S 000	Initial Comments Facility reported incicent of June 26, 2023/IL161534	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 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. 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.	S9999		

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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 observation, interview, and record review, the facility failed to ensure a resident was propelled safely in the facility parking lot to avoid a fall. The resident fell forward out of her wheelchair and landed on the asphalt, sustaining progression of an existing neck fracture, a shoulder dislocation, and a hematoma on her forehead. This applies to 1 of 5 residents (R1) reviewed for falls in the sample of 5.

The findings include:

The facility incident reported to the Illinois Department of Public Health on 6/27/23 (occurring on 6/26/23) showed R1's incident "occurred at 10:46 AM while R1 and fellow residents were being escorted around facility property by CNAs [Certified Nursing Assistants]. R1's front wheelchair became stuck in grated manhole cover causing R1 to lean forward and fall from her wheelchair .... Resident was admitted (to local hospital) with a [fracture] of C2

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[cervical- second bone in the neck] ...." R1's 6/29/23 Physical Therapy referral showed R1 was re-admitted with a diagnosis of C2 fracture from a fall "in the facility compound while CNAs were pushing [R1] for a morning walk. Patient fell forward out of her [wheelchair] and no leg rests were in place ..."

R1's hospital discharge summary (6/26/23 result date) included her Computerized Tomography (CT) of her spine and it showed "IMPRESSION: Unstable complete transverse base of the dens fracture of C2 [second bone in neck] .... this fracture has progressed from the prior CT scan dated 12/11/2022 ..." The "narrative" section in R1's hospital discharge summary also showed a left shoulder Xray from 6/26/23 with "probable AC joint separation [collar bone separating from the shoulder blade] ..." R1's 6/26/23 brain CT findings showed "There is a small left lateral frontal scalp hematoma, measuring 0.5 centimeters in thickness."

On 7/6/22 at 11:51 AM, V12 (Maintenance Assistant) assessed the area in the parking lot where R1 fell out of her wheelchair. The area had a round metal manhole cover V12 measured as approximately 22 inches across and it was painted yellow. The manhole cover was set down three-quarters of an inch below the surrounding asphalt, and the surrounding asphalt gradually sloped down toward the cover. V12 measured over 10 feet of clearance on one side between the manhole cover and the parking spaces, and six feet 10 inches of clearance between the manhole cover and the lawn on the other side.

On 7/5/23 at 10:36 AM, R1 was lying in bed wearing a hospital gown and sleeping. R1 was

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wearing a cervical collar. R1's July 2023 Physician Order Sheet showed a 7/5/23 order of "NURSING REHAB: Cervical neck brace- keep neck brace in place at all times for at least 12 weeks from date of re-admission OR until re-evaluated by orthopedics..."

On 7/6/23 at 9:46 AM, R1 was in bed in a hospital gown and had discoloration on her left forehead. R1 stated she recalled falling outside. R1 stated she did not have leg rests on her wheelchair at the time of her fall and she did not want to get out of bed because it hurts to move.

R1's 6/10/23 Minimum Data Set 6/10/23 showed R1 is cognitively intact and required limited assistance with locomotion off the unit. R1's 7/5/23 V14 NP (Nurse Practitioner-Hospice/Palliative) note from 1:21 PM showed R1 "suffered a fall last month, with head injury. She was sent to the hospital, and it has been determined that she has a progression of her dens fracture .... She had been mobile prior to the fall and had been able to wheel herself around the hallways but has become primarily bed bound ...."

On 7/5/23 at 11:31 AM, V5 (Restorative Aide) stated on 6/26/23 at about 9:30 AM, she and V4 (Restorative Aide) were escorting R1 with two other residents on a walk around the building through the parking lot. V5 stated they were all walking side by side, and she was the one pushing R1 in her wheelchair. V5 stated they were talking to the residents as they were walking. V5 stated R1's back left wheel caught the edge of the manhole cover and R1 fell forward out of the wheelchair before she could grab her. V5 stated R1 fell on her left side and a bump formed on R1's left forehead. V5 stated

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every resident has foot pedals in their room. It is part of their (staff's) job to assure residents have leg rests available when they go out.

On 7/5/23 at 10:55 AM, V4 (Restorative Aide) confirmed she and V5 were walking outside the facility with R1 and two other residents. V4 stated she was pushing one resident's wheelchair, and another resident was walking on her left. V4 stated V5 was on her right, pushing R1 in her wheelchair. V4 stated V5 pushed R1 over the manhole cover and R1 went forward, falling out of her wheelchair. V4 stated R1 hit her left head and left side. V4 stated when residents are transported by staff, they should have leg rests in place on their wheelchairs.

On 7/7/23 at 3:15 PM, V16 (Occupational Therapist- Registered) stated residents should have leg pedals on if they are in the parking lot because of the uneven surfaces. V16 explained the use of leg pedals on a wheelchair helps position the hips back if there is a sudden "jerk" while in motion. V16 stated leg pedals keep the knees up and keep the person back in their seat. V16 added that when residents go out for appointments, they must use leg pedals for traveling on the bus for safety. V16 stated, "It's a standard." V16 stated since the fall, R1 has primarily been on bedrest except for therapy at the bedside. V16 stated, "It's a big change for her (R1)...it's her preference right now." V16 added R1 does not want to get out of bed and she says it is too much discomfort and pain, adding R1, "knows she fell out of the chair."

On 7/7/23 at 3:10 PM, V6 PT (Physical Therapist / Director of Physical Therapy) stated that on 6/26/23 when R1 fell, she heard a commotion out front and went to the parking lot. V6 stated she

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saw R1 on her back and R1 said something like, "take me, I'm hurting." V6 stated residents do not need leg pedals on their wheelchairs if they are just sitting in the front entrance because staff is always there. On 7/5/23 at 2:23 PM, V6 stated when she saw R1 on the ground in the parking lot, her wheelchair did not have leg rests in place. V6 stated leg rests are important to prevent falls from the wheelchair.

On 7/5/23 at 3:36 PM, V3 ADON (Assistant Director of Nursing) stated R1 had swelling on her right forehead and an abrasion on her left knee. V3 stated R1 has a bag on the back of her wheelchair for her leg rests, but he did not recall if the leg rest or a seat cushion were in use. V3 stated when R1 is being transported outside of the facility, there should be leg rests in use.

On 7/6/23 at 11:31 AM, V11 CNA (Certified Nursing Assistant) stated if she is taking a resident outside, they need to have their leg rests in place. V11 stated the leg rests provide balance and safety.

On 7/7/23 at 10:37 AM, V13 NP (Nurse Practitioner) stated R1's current C2 (cervical) fracture post-fall was a progression of a previous fracture she sustained at the end of last year. V13 stated there was enough space outside to avoid pushing R1 over the manhole cover.

On 7/7/23 at 3:05 PM, V15 RN (Registered Nurse) stated she heard about R1's fall and that staff should have used leg pedals for R1, adding, "I think they should have avoided the manhole cover."

On 7/7/23 at 11:58 AM, V2 DON (Director of Nursing) stated the facility does not have a policy

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S9999	Continued From page 6 for transporting residents, but it is the facility's practice for residents to have leg rests in use when being escorted by staff. V2 stated staff should make sure the wheelchair is in working condition, the footrests are in place, make sure it's not raining or windy, and avoid potholes or any dips in the ground. R1's fall risk care plan (initiated 10/11/18) showed a 10/11/18 person-centered care plan intervention of: "I would like staff to provide me a safe environment: even floors, free from spills and/or clutter..." (A)	S9999		