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
	IL6005250	A. BUILDING: ________ B. WING ________	C 07/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA SALLE COUNTY NURSING HOME	1380 NORTH 27TH ROAD OTTAWA, IL 61350

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S 000	Initial Comments Investigation of Facility Reported Incident of June 18, 2023/IL161491	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b)4)5) 300.1210d)3)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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which	S9999	Attachment A Statement of Licensure Violations	

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allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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.

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.

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:

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3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

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.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview and record review the facility failed to ensure one resident (R3) was safe to operate a motorized wheelchair of three residents reviewed for accidents. This failure resulted in R3 sustaining a foot laceration requiring stitches at the hospital.

Findings include:

Facility policy/Falls and Incident Reporting documents:
Each incident involving a resident shall be documented on a standard Incident Report Form. All incidents are treated in that same manner. Incidents are identified as any event or occurrence out of the ordinary process of care including such events, but not limited to, the following:
2. Wheelchair accidents

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Current Physician Order Summary indicates R3 has diagnoses that include Cerebral Palsy, Quadriplegia, Anxiety and Bipolar Disorders.

On 7/5/23 at 10:30am R3 was sitting in an electric wheelchair in the dining room during an activity.

On 7/5/23 at 1:30pm R3 was in bed resting with her electric wheelchair at her bedside. R3's left foot had several layers of gauze and stretch bandages around her left foot and ankle. R3 became irritated and argumentative when questioned about her accident with her motorized wheelchair. R3 stated there was nothing wrong with the speed of the chair and no one was going to slow it down.

Employee Incident Report of Injury/Incident dated 6/17/23 indicates V8 (Activity Aide) was helping R3 with the pop machine and when R3 moved closer she hit V8 with her power chair and pushed V8 into the wall and pinned V8 against the wall. Report indicates V8 reported "(R3) couldn't stop (the chair)."

R3's medical record did not include any documentation or investigation of R3 pinning V8 against a wall or being unable to stop the wheelchair.

Investigative Summary Report dated 6/23/23 at 7:15am indicates staff responded to R3 room due to R3 screaming. R3's electric wheelchair, which was occupied by R3 at the time, was facing R3's bed with the foot portion of the wheelchair being under R3's bed with R3's foot being trapped between the bed and the wheelchair. An injury was noted to R3's left foot with a 4.4 cm (centimeter) in length laceration to the upper portion of left foot with drainage and underlying

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exposed tissue. Summary indicates R3 stated she got her foot stuck under the bed. R3 was sent to the hospital for treatment and returned with six sutures.

Nurse Note dated 6/23/23 at 7:37am indicates staff were called to R3's room, "Large gash to top of left foot 4.4 inches long, fatty layer exposed." Note indicates efforts were made by staff to close wound and gauze wrapped to control bleeding; top of foot starting to bruise. Note indicates physician notified with orders to send to hospital via "911."
Note indicates R3 stated her foot became stuck under bed while in electric wheelchair and obtained laceration to top of left foot.

Nurse Note dated 6/23/23 at 11:14am indicates R3 returned from the hospital via ambulance with stitches to left foot and wrapped with supportive bandages.

Nurse Note dated 6/23/23/at 11:52am indicates R3's Family/POA (Power of Attorney) was notified of incident of R3 running into her bed with her electric wheelchair causing injury to left foot. Note indicates "this incident follows the incident regarding (R3) pinning a staff member against the vending machine causing her to be off work." Note also indicates "Staff have had to get her electric wheelchair unstuck from her bed before." Note indicates "This causes a safety concern regarding her and other residents. POA was notified of safety concerns and need for a wheelchair evaluation. A regular wheelchair will be used until the evaluations completed. Ombudsman updated with our concern with electric wheelchair and safety concerns."

Nurse Note dated 6/26/23 at 4:03pm indicates

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staff spoke with motorized wheelchair company regarding R3 electric wheelchair, appointment made for them to come out and assess electric wheelchair and speeds, scheduled for 7/18/2023.

Motorized Wheelchair Evaluation Form dated 2/6/23 (admission) and 5/3/23 (quarterly) both indicate R3:
Does have a physical limitation that prevents R3 from accomplishing mobility-related activities of daily living.
Does not have the mental capacity sufficient for safe operation of mobility-related functions with the use of a motorized wheelchair.
Is unable to be trained for safe operation of a motorized wheelchair.

Wheelchair Clinic Form dated 6/26/23 for Electric wheelchair indicates "(R3) was assessed for her ability to operate her wheelchair in several environments. In close conditions within resident room during which (R3) had light contact with several objects due to delayed reactions with a possible solution being to reduce the top speed of the propulsion of her wheelchair in which (R3) was highly resistant to the idea."

Wheelchair Clinic Form dated 6/26/23 for Standard wheelchair indicates "(R3) evaluated for fit in a standard wheelchair following difficulties encountered in operation of her electric wheelchair with two accidents involved."

On 7/5/23 at 2:30pm V7 (Restorative Registered Nurse) stated "I do believe (R3) is a little at risk for accidents - a safety issue. I believe the speed needs to be reduced on the chair, but (R3) won't even hear of it." V7 stated he became aware of R3's accident with the employee through the nurse note later documented on 6/26/23. No one

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told me about the incident when it happened. I should have been told and I didn't know of any other incidents with her feet or footrests getting stuck under her bed until now." V7 stated R3's motorized chair was taken away after she injured her foot, but the other chairs didn't fit her right, so they had to put R3 back in her motorized chair. V7 stated they are unable to adjust the speeds so the company will come out to adjust. V7 further stated he didn't know why he documented that R3 did not have mental capacity to operate the motorized chair and couldn't be trained in the admission and quarterly assessments.

Care Plan dated 2/17/23 indicates R3 has an electric wheelchair which R3 uses on a consistent basis with intervention to assess speed setting quarterly and as needed.
Care Plan was not updated/revised to include R3 pinning staff against the wall, any incidents with R3's feet or footrests becoming stuck under her bed or the incident causing injury to R3's foot.

On 7/6/23 V1 (Administrator) stated that the facility did not have a Motorized Wheelchair Policy or Consent until 7/6/23.

"B"