STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003172	A. BUILDING: _____ B. WING _____	C 08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORA GARDENS CARE CENTER	701 SHADWELL AVENUE FLORA, IL 62839

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S 000	Initial Comments Complaint Investigation: 2456161/IL176359	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 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		

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S9999	Continued From page 1	S9999		

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.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and record review the facility failed to safely secure a resident during transport for 1 of 3 residents (R2) reviewed for accidents in a sample of 3. This failure resulted in R2 sustaining a 3 by 5 inches laceration to her left leg that became infected and required a wound vac.

The findings included:

R2's Admission record documents an admission date to the facility of 9/08/2023 with diagnoses including morbid (severe) obesity due to excess calories, unspecified atherosclerosis of native arteries of extremities, bilateral legs, lymphedema, not elsewhere classified, other specified and diabetes mellitus with diabetic autonomic (poly) neuropathy.

R2's Minimum Data Set (MDS) dated 6/17/2024, documents in Section C, Cognitive Patterns, that R2 has a Brief Interview for Mental Status (BIMS) score of 15 indicating R2 is cognitively intact. The same MDS section GG0170, Mobility documents the use of a motorized scooter and section I8000, Active diagnoses documents lymphedema, not

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elsewhere classified.

R2's care plan documents a focus area of, "The resident has limited physical mobility" with a documented intervention of the resident uses a motorized wheelchair with supervision from staff.

On 8/07/2024 at 11:33 AM, R2 was observed sitting in her recliner in her room reading a book. R2's left leg had an ace bandage wrap applied around her left lower leg with a wound vacuum in place. R2 had a scant amount of reddish colored drainage in the wound vacuum line.

On 8/07/2024 at 11:35 AM, R2 stated that V12 (Social Service Director) had been transporting her in the facility van to her eye appointment. R2 stated V12 did not buckle her scooter in the van because they were not going very far from the facility. R2 stated she held on to the cup holders on both sides of her in the van during transport to and from the eye appointment. R2 stated on the way back to the facility from her eye appointment, V12 missed the street to turn on to go back to the facility and slammed on the brakes to make a turn into the local diner parking lot. R2 stated when V12 hit the van brakes, her scooter went forward, and she hit her left lower leg on a metal piece on the seat in front of her. R2 stated after hitting the seat with her leg, she looked down and she noticed she was bleeding and that there was a gash in her leg. R2 stated she requested V12 take her to the emergency room. R2 stated when they arrived at the emergency room, a nurse came outside, applied some gauze to her leg and took her in to be evaluated. R2 stated she is under the care of a wound physician at this time to help her leg heal. R2 stated that she had never asked staff to not buckle her in.

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S9999	Continued From page 3 On 8/08/2024 at 11:20 AM, V1 (Administrator) stated she had not been aware that R2 was not secured in the facility van during her transport on 7/12/2024. V1 stated her previous Director of Nursing and Assistant Director of Nursing handled this investigation because she went on vacation. V1 stated V12 (Social Service Director) did tell her before that R2 did not want her scooter buckled in because it caused her scooter to be pushed backwards and she did not like it. V1 stated that V12, V13 (Director of Nursing/DON) and V14 (Assistant Director of Nursing/ADON) are no longer employed at the facility. On 8/08/2024 at 2:00 PM, V13 (DON) stated V14 (ADON) is the person who interviewed R2 about this incident. V13 stated, she was made aware after the incident by V1 that R2's scooter was not secured in the van during transport. On 8/08/2024 at 2:10 PM, V14 (ADON) stated she was in V1's office when V12 called V1 to notify her of the incident with R2's leg. V14 stated, V12 did call V1 upon arrival to the local emergency room with R2. V14 stated, V12 notified V1 that she made a quick turn in the van which caused R2 to slide forward, hitting her leg on a metal piece on the passenger seat in front of her that caused a gash to R2's left lower leg. V14 stated, the facility had been using a van from a company that was not the normal van used for transporting residents, and when R2 and V12 returned to the facility after the emergency room visit, V1 and herself went out to the van to evaluate what caused the incident to happen. V14 stated, when they arrived at the van, R2 was observed sitting in her power chair in the back of the van, however, R2's power chair does not fit into the lock mechanisms for the wheels, like the	S9999		

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wheelchairs would. V14 stated, R2's power chair did not have the emergency brake on either. V14 stated, she explained to V12 (Social Services Director) that she should have notified them prior to leaving the facility with R2 about her wheels not locking into place so they could have made other arrangements for transporting her. V14 stated, V12 said her and R2 were in a hurry to get to the appointment because they were running behind.

R2's Statement provided with investigation documents from the facility dated 7/12/2024 documents "When she turned my scooter wasn't locked in. I flew up against the seat. My leg was cut on the seat belt. My scooter just went with me."

V12's statement provided with investigation documents from the facility dated 7/12/2024 documents in part, "I passed (Name of Street) since I felt turn would be too sharp and tapped brakes in prep to turn into the parking lot of (local restaurant). As I tapped brakes (R2's) motorized scooter came forward to settle between the two seats. (R2) made a pained sound and I finished pulling to complete stop in parking lot."

R2's local Hospital Emergency Room report dated 7/12/2024 documented left lateral mid leg with significant subcutaneous gash of 3 inches by 5 inches. Wound was irrigated and attempted wound closure not successful. Adaptive dressing, oral antibiotic (Cephalexin 500 milligrams orally 4 times a day) and outpatient follow up.

R2's Order Summary Report dated 7/12/2024 documented referral to local wound clinic related to laceration on left lower leg below the knee.

R2 ' s Progress Note dated 7/12/2024 at 2:55 PM

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documented to keep compression dressing on for a few days, watch for signs and symptoms of infection, Cephalexin 500 milligrams by mouth every day for seven days, elevate legs as much as possible.

R2's orders from the local Wound Center Physician dated 7/17/2024 at 1:00 PM, documented wound cleanser to site one time a day and bacteria identified in unspecified specimen by anaerobe culture, left lower leg, done at wound center.

R2's orders from the local Wound Center Physician dated 7/24/2024 at 2:00 PM, documented wound cleanser to site one time a day.

R2's orders from the local Wound Center Physician 7/30/2024 at 12:45 PM documented, wound vac to wound continuously at 125 millimeter of mercury pressure. Change three times weekly and Cephalexin 500 milligram tablet, four times daily for 14 additional days.

R2's Order Summary Report dated 7/12/2024 documented to elevate legs as much as possible every day and night shift for wound.

The facility policy titled "Van Usage Policy and Procedure" (undated) documents under Procedure step 3 " c. wear seat belts anytime the vehicle is in motion and require all passengers to wear seatbelts. d. Ensure all residents and wheelchairs are safely secured. "

(A)