STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004907	A. BUILDING: _____ B. WING _____	C 01/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEYVILLE NSG & REHAB CENTER	1001 SOUTH STATE STREET JERSEYVILLE, IL 62052

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S 000	Initial Comments Complaint # 1740240/IL91041	S 000		
S9999	Final Observations Statement Licensure Violations: 300.610a) 300.1210b) 300.1210d)6 300.3240a) 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 care shall include, at a minimum, the following and shall be practiced on a 24-hour,	S9999	**Attachment A** **Statement of Licensure Violations**	

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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 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident

These Regulations are not met as evidenced by:

Based on record observation, record review and interview, the facility failed to prevent a fall from a wheelchair while pushing a resident from a dialysis provider for one of 4 residents (R3) reviewed for falls and safety during transport in the sample of 10. This failure resulted in R3 sustaining fractures of the cervical spine, nose and 2 ribs, with traumatic subdural hematoma, subarachnoid hemorrhage and facial and right elbow lacerations.

Findings include:

The ECR (electronic clinical record) for R3 documents diagnoses, in part, as Chronic Pain, End Stage Renal Disease with Renal Dialysis, Weakness, History of Deep Vein Thrombosis of Lower Extremity and CHF (Congestive Heart Failure). The Minimum Data Set (MDS) dated 12/14/2016, documents R3 has a BIMS score (Brief Interview of Mental Status) of 15, with no impairment in cognition, requires extensive assistance with transfers, does not ambulate, has limited range of motion in all 4 extremities and has unsteady balance, that only stabilizes with staff assistance. The MDS documents R3 uses a

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wheelchair for her mode of transportation.

The Occurrence Report, dated 1/04/2017 at 4:30 PM, documents R3 fell over face first from the wheelchair, hitting her face on the concrete sidewalk as E3, Certified Nurses Aide (CNA) was pushing her down a downward sloping sidewalk in front of the nearby general store. The Occurrence Report documents 911 was called, and R3 was transported to the local hospital for evaluation and treatment.

On 1/18/2017 at 10:40 AM, Z1, Manager of the general store played the video, dated January 2017, with images that the store's camera had taken and recorded on 1/04/2017 at 4:29 PM of the front of the store and the main entrance/exit. This video documents E3 was pushing R3 on the sidewalk past the front entrance door of the store. R3 was in a wheelchair with no foot pedals, and her head and body were covered with a blanket. E3 had both hands on the handgrips of the wheelchair as she was pushing and guiding R3 down the sidewalk. As the sidewalk began to slope downward, R3's wheelchair moved a little faster, and at 4:30 PM R3 rapidly pitched forward from the wheelchair and landed face first onto the concrete sidewalk. R3's wheelchair was on top of her. A customer approached R3 and covered her with a blanket, as E3 left the area. R3 remained on the sidewalk in the same position. The video documents at 4:33 PM on 1/04/2017, Z1 came out of the front entrance. At 4:37 PM, an ambulance and a local police officer arrives at the scene. The first responders, with help from others that had approached R3, turned R3 over onto a backboard. No cervical collar was applied before R3 was lifted by the ambulance staff and placed into the waiting ambulance at 4:39 PM. The video documents the ambulance carrying R3 left the

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parking lot in front of the general store at 4:40 PM.

On 1/18/2017, at 10:40 AM, Z1 reported he did not witness R3's fall, but was there to assist afterward. Z1 stated, in part, "She (R3) hit her head. There is a black stain on the sidewalk from bleeding from her face. There was a lot of blood. I put cat litter on it to soak it up. When I came out, she was still on her face .The staff were talking to her (R3), and she was responsive. I don't think there were any foot pedals on the wheelchair. By the time I got there, an ambulance got called. Two ladies from the nursing home (facility) came to watch the video. One was the Administrator, (E1). A customer covered (R3). The staff person (E3) had left briefly. There was no snow or ice on the sidewalk. (Z3) of the (local) police also arrived."

On 1/18/2017 at 11:08 AM, the sidewalk near the front entrance to the general store had a large dark substance mixed with cat litter staining the sidewalk. At that time, Z1 identified it as the blood stain left by R3. Before the stain, the sidewalk began to slope downward and there was a large 8 to 10 inch wide and 1 inch deep, open area in the right side of the crack, where the concrete had eroded away, leaving a hole.

On 1/17/2017 at 2:25 PM, E3, CNA stated, in part, "(R3) had a scarf around her neck. It was cold and windy. I asked her if she wanted me to cover her face, and she said yes. I covered her (R3) face-blanket up to the hood with fuzz around it, and tucked the edge of the blanket under her legs. I wheeled her down the sidewalk. We got between the (general store) and (grocery store). The sidewalk inclined-slanted downward. (R3's) wheelchair began going faster. I leaned back to

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slow down the wheelchair. (R3) started to lean forward and fell out of the wheelchair. She is a bigger lady. I couldn't see due to being in back of the wheelchair. There were no foot pedals on the wheelchair. I started to panic. A lady jumped out of a truck, and said she would stay with (R3). I ran to the facility for help and came back. A man had 911 on the phone. A nurse, (E5, Registered Nurse, RN) came over. I was freaked out. She said you need to calm down, and I came back (to the facility). She was not knocked out and was talking. She (R3) said the ground was cold and wanted to get off of it. I just saw blood on the sidewalk. I work evenings and normally, I just go and get them (from dialysis). I have gotten her (R3) a couple times before."

On 1/17/2017 at 2:10 PM, E5, RN stated, in part, "A staff member said she was on the ground. I got there and between (general store) and (grocery store), (R3) was between the two. She was laying on the sidewalk face down-head was turned to the left. All I could see was blood on the concrete. She (R3) was talking and wanted to get up off of the sidewalk. She said she was cold. The store manager called 911. I knew (E4, RN) and I couldn't get her up by ourselves. She is a large lady and uses a mechanical lift. (E4) took her pulse. The ambulance arrived quickly. I moved the wheelchair over and the (urinary) catheter bag was still connected to the wheelchair. (R3's) feet were still under the wheelchair. She was placed on a backboard. No cervical collar was applied. We all lifted (R3) to the stretcher to the ambulance. I sent her glasses with her. One of the lenses came out. The glasses had blood on them."

On 1/17/2017 at 1:53 PM, E4 was interviewed and told the same story as E5. E4 reported the

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facility has transported residents to and back from the nearby dialysis center by wheelchair for the 2 years she has been employed at the facility.

The local ambulance record for R3 dated 1/04/2017 at 4:38 PM, documents, in part, "Patient (pt) complaining of pain to her chin, neck and head. Pt had about 1,000 ml (milliliter) of blood loss on the ground. Pt was log rolled onto backboard. Unable to get a c-collar in place due to size of patient's neck. Pt was starting to spit up blood and airway was starting to become compromised."

The local hospital emergency department (ED) record documents R3 arrived at 4:55 PM on 1/04/2017. The ED record documents, in part, "Patient has noted forehead avulsion, right elbow skin tear and pain reported to neck, head and chin. Pain all reported at 10/10." The ED record documents R3 was air lifted via medical helicopter to a hospital that provided a higher level of care on 1/04/2017 at 6:55 PM.

The History and Physical (H&P) for R3 from the local hospital, dated 1/04/2017 at 5:18 PM, documents, in part, "Patient (R3) sustained a large 4 X 2 cm (centimeter) V shaped laceration to right frontal area, small laceration to upper tip of nose, skin tear to right elbow. Patient complains of intractable pain to neck, head and chin. Bilateral raccoon appearance of eyes."

The CT (computed tomography) of R3's head, dated 1/04/2017 at 11:32 PM, documents, "small amount of acute subarachnoid and subdural hemorrhage involving the frontal lobes. Cervical CT-Type 2 dens fracture which should be considered unstable. The fx (fracture) displacement as a risk for vertebral artery injury

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to which could be better assessed with CT angiogram as indicated. CT face-nasal fx, small densities in the post nasopharynx. Condition-critical."

The H&P, dated 1/04/2017, from the second hospital R3 was transferred for a higher level of care documents R3 also sustained, "Nondisplaced right fifth through ninth anterior rib fractures." R3's Discharge Report from this hospital documents R3 left the facility on 1/07/2017 at 10:43 AM by ambulance to a hospital based rehabilitation unit.

On 1/18/2017 at 4:03 PM Z2, Physician reported he was aware of R3's fall with numerous fractures and injuries. Z2 reported he knew R3 expired on 1/15/2017. Z2 stated, in part, "Her (R3) renal functioning was very brittle. I had discussed a probable malignancy of the left upper chest that was found with a screening for cataract surgery with her and her family in December 2016. They did not want chemotherapy. There was trouble keeping her blood counts up. She was not in good health. I don't know the cause of death. Personally, if the fall contributed to her death, she would have died sooner."

R3's Care Plan, dated 12/21/2016, documents in part, "Resident is at risk for falls or trauma related to unsteady balance and use of multiple meds (medications). Receives hemodialysis 3 times weekly and receives narcotic pain management. Transfers are 2 assist with (mechanical lift) and verbal/physical cues. If injury should occur, alert family and physician as soon as possible, administering first aide as indicated. She has varying ability to participate in ADL's (activities of daily living), noted more after dialysis treatments."

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S9999	Continued From page 7 On 1/18/2017 at 12:06 PM, E2, Director of Nursing (DON) reported the facility had no protocol or policy and procedure for transporting residents to the dialysis center in the strip mall that is behind the facility until after R3's fall on 1/04/2017. The State Of Illinois Certificate of Death Worksheet, certified on 1/17/17, documented " Describe How Injury Occurred: Decedent was in wheelchair that overturned at her extended care facility. " R3 ' s Death Certificated documented the Cause of Death as " Complications of Cervical and Rib Fractures. " The facility's policy and procedure, dated 12/2007 and entitled, 'Falls and Fall Risk, Managing' documents, in part, "Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling." (A)	S9999		