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	IL6010094	A. BUILDING: _____ B. WING _____	C 06/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINNING WHEELS	701 EAST 3RD STREET PROPHETSTOWN, IL 61277

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S 000	Initial Comments Facility Reported Incident Investigation of 06/18/2021/IL135433	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)3) 300.1210d)6) 300.3240a) 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. 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	S9999	Attachment A Statement of Licensure Violations	

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resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

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:

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.

300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements were not met as evidenced by:

Based on observation, interview, and record review, the facility failed to safely secure a resident during transport in a facility vehicle, ensure necessary care and services were provided by not assessing a resident after an incident while in a facility vehicle and to assess a

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resident after a return from a hospital stay. The facility failed to investigate an incident which occurred in a facility vehicle until five days later for one of eight residents (R1) reviewed for quality of care in the sample of 8. These failures resulted in R1 remaining untreated in the facility for five hours after suffering bilateral lower leg fractures.

R1's face sheet (printed 6/30/21) showed a 45-year-old male admitted to the facility on 12/28/20. Diagnosis listed included quadriplegia, colostomy, liver disease and pressure ulcers. R1's 4/30/21 facility assessment showed he is cognitively intact and has a traumatic spinal cord dysfunction.

On 6/30/21 at 8:10 AM, V3 Activity Aid (driver of van for 6/18/21 incident) said he was driving the facility van on 6/18/21 with R1 as a passenger. V3 said "I came to a stop sign and stopped more abruptly than I usually would. V3 said "I think I didn't check how tight his (R1's) seat belt was". I think the momentum from that caused him (R1) to fall. R1's hands were on the floor and his hips and butt stayed in the chair, but he came forward. R1's catheter bag came detached during the incident and he asked me to help him reconnect it which I did. When I got back to the facility, I told my supervisor (via text message) that "I pressed the brakes too suddenly and R1 had fallen". R1 told his nurse. I believe the nurse was V4 Registered Nurse (RN)". V3 said I was asked (on 6/22/21) to write a report of the incident and bring it in when I returned to work on June 23, 2021.

At 8:39 AM, V4 RN said V3 told her "R1 fell forward due to a loose seatbelt. When V4 talked to R1. R1 said his whole wheelchair fell forward and almost hit the other resident in the van". R1

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was wet with urine so I asked the staff to put R1 in bed. R1's catheter came apart during the fall in the van, so he was wet. Usually after an incident or hospital stay, I would do a complete head to toe assessment. I didn't examine R1 because it was shift change and he was still in his chair". The nurses work 12-hour shifts-6-6. I told the oncoming nurse, V8 Licensed Practical Nurse (LPN), he needed a head to toe assessment.

At 8:42 AM, V6 Orthopedic Provider said R1's lower leg fractures would not have occurred without an impact injury (not caused by osteopenia).

On 6/30/21 at 9:50 AM, R1 was supine in bed. He was alert and oriented to person, place and time. R1 had bilateral hinged braces to both legs extending from the thigh to lower legs. There was residual bruising to both anterior lower legs. R1 had a suprapubic catheter and colostomy present. R1's wheelchair was near the bed. The footrest was one flat piece of metal with a tread on top to support both feet when up. There was a lap seat belt attached to the chair. R1 became visibly upset (tears in eyes) when talking about the incident on 6/18/21. R1 said on 6/18/21 he was in the facility van for an outing and on the way back the driver hit the brakes "too hard". R1 said his wheelchair seat belt was loose and had about 5-6 inches of slack between his torso and the belt. R1 said he cannot secure or adjust his seat belt due to his decreased hand dexterity. "I ended up on all fours". I put my hands down in front of me, so I didn't hit my face on the floor. My catheter got disconnected due to the momentum and urine was leaking on me and the van floor. "I am paralyzed from the chest down".

R1 said nobody at the facility looked at him for

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injuries after he returned from the outing. "I started having bad chills later that night. I usually have a UTI (urinary tract infection) because of my catheter". I believe my symptoms were "automatic dysreflexia" due to the pain in my legs. I don't feel pain like normal people. Sometimes my body has other symptoms to show distress. I made them send me to the hospital because I knew something was wrong with me.

R1 said part of him was in contact with the floor. His hips and butt stayed in the chair, but he came forward". V3 said "I heard his CD bag fall out of the chair and he cried out as well and told me to stop". "I grabbed him under his arms to get him back to a seated position. He was bent "pretty far forward" so his fingers could touch the ground. He "couldn't straighten himself up". I put an extra shoulder strap on him. The brakes are "really touchy".

At 10:50 AM, R8 was interviewed with the assistance of V7 CNA Coordinator due to R8's communication deficits. V7 confirmed all question responses prior to documentation. V7 confirms R8 is a reliable historian. R8 said he was in the facility van with R1 on 6/18/21 on the outing. R8 said he was not injured. R8 said R1 was behind him in the van. R8 said R1 fell forward out of the chair during an abrupt stop. R8 said R1's chair didn't fall over but R1 fell out of the chair. R1 was on the floor (of the vehicle) on his hands and knees.

At 10:57 AM, V8 LPN said she got report that he (R1) went over in his wheelchair while in the van and there were no injuries". V8 LPN said she didn't do a head to toe assessment on R1 6/18/21. "I wasn't the nurse that was there when he came back. I got report that he (R1) went over

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in his wheelchair while in the van and there were no injuries". "The nurse who accepts the resident back should do a head to toe assessment. V4 didn't tell me I had to do the assessment". "I never did a head toe assessment for injuries.

At 12:19 PM, V11 Director of Therapy said if R1's center of gravity is beyond his base of support he has limited control (of upper body). R1 has limited core control. I can't see how he could end up with his hands on the floor. I don't believe he could normally reach his feet. A chest belt would be beneficial for a resident with poor trunk control.

At 3:29 PM, V12 wound nurse said "I found (R1's) bruises on 6/22/21. I notified the Director of Nursing and had her look at the wounds. There were bruises and blisters that were not there the last time I saw him. Staff nurses are to do a head to toe assessment when a resident return from a hospitalization and after an incident".

At 3:50 PM, V2 Director of Nursing said a nursing assessment should be done as soon as possible when a resident returns from a hospitalization and after a resident incident. This includes a head to toe assessment. This should be documented in the progress notes. It's important to assess the resident after a hospitalization to identify skin issues that were not there when they left the facility. After an incident, it's important to see if there were any injuries from the incident. "No new skin issues" is not an adequate assessment. An assessment should include vital signs.

R1's progress note (authored by V4) dated 6/18/21 at 5:43 PM showed he returned to the facility from an outing. It was reported to the nurse that R1 fell forward due to a loose wheelchair seat belt. R1 told the nurse his whole

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chair came forward and R1 had to brace himself to keep his face from hitting the floor. R1's progress note (authored by V8) dated 6/18/21 at 22:48 showed R1 was very persistent on going to the hospital and was transported there at 10:41 PM. R1's 6/22/21 progress note showed R1 returned to the facility from the hospital stay on 6/21/21 at 5:15 PM. R1's progress note dated 6/21/21 at 11:15 PM showed no new skin issues observed (after return from hospital stay). Photographs taken 6/19/21 at the local hospital showed diffuse swelling and bruising to both of R1's lower extremities. R1's medical record showed the first skin assessment with findings dated 6/22/21 at 10:30 AM. This note authored by V12 showed bruises blisters and scabbed areas to both lower legs.

R1's 6/22/21 progress note from a wound clinic visit showed the resident presented for ongoing wound care, however, the resident stated he fell a few days ago during an outing. He states he fell forward and landed on his shins. He notes that he has observed bruising in the area, but as he is insensate, he does not appreciate any pain. He is also bedridden secondary to a cervical spine injury. New acute findings of the lower extremities, there is diffuse ecchymosis with minor blistering involving the anterior aspects of both proximal tibia areas. This is a 45-year-old male who has fallen recently and now has concerning bruising involving the anterior aspects of both distal lower extremities. We obtained bilateral x-rays of the lower extremities and confirmed bilateral acute fractures.

R1's 6/22/21 right tibia-fibula radiology report showed acute proximal right tibial fracture with slight impaction and incomplete fracture of the proximal right fibula. R1's 6/22/21 left tibia-fibula

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S9999	Continued From page 7 radiology report showed a comminuted fracture of the tibial plateau with interarticular extension. Significant displacement at the fracture site. The facility's investigation of the 6/18/21 incident does not show any interviews prior to 6/23/21 (5 days after the incident). The initial note in the investigation is only a summary of nursing progress notes. R1's progress notes do not show any documentation of a head to toe nursing assessment done after return to the facility on 6/18/21 or 6/21/21. This documentation was requested on 6/30/21 and none was received. The facility's incident investigation report showed "staff retraining in relation to incident of resident tipping forward in van causing potential injury". The van driver (V3) said he had to make an abrupt stop and assist R1 to an upright position. V3 said R1's seat belt was a little loose. R1's interview showed "the brakes were touchy" The seatbelt was loose and V3 stopped abruptly and I fell forward and my hands were on the floor of the van to prevent me from falling on my face. I think I was on all fours. The facility's 5/22/2018 Transportation Guidelines and Training Manual showed all employees who utilize the vans must follow designated speed limits and safety precautions along with cell phone policies and state laws. Chest straps are provided for residents who have trouble with balance and should be used at the driver's discretion. Stopping: The ability to stop your vehicle safely should be considered when deciding your speed. While braking, push the brake steadily-do not pump. As you get closer to the stop sign, let up on the brake slightly-this will give you a slow, steady stop without a jerking motion. If there is an accident with an injury and you are not at the facility, the first thing to do is	S9999		

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S9999	Continued From page 8 dial 911. The facility's 3/17 Return from Hospital Transfer Policy showed patient will be assessed by nurse upon return for vital signs, skin condition, weight, etc. Patient's condition will be documented on at least once a shift for 72 hours. The facility's 3/17 Accident/Sentinel Event Investigation Policy showed the initial investigation will be done by the supervisor, Administrator and/or Assistant Administrator immediately after the victim has been properly cared for, and there is no more threat of injury. An accident is a series of events that takes place and causes the undesirable loss. To maintain a quality safety environment, accidents and close calls will be investigated. (A)	S9999		