STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005649	A. BUILDING: _____ B. WING _____	C 11/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MACOMB POST ACUTE CARE CENTER	8 DOCTORS LANE MACOMB, IL 61455

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S 000	Initial Comments Complaint Investigation 2228750/IL152886 Facility Reported Incident of 10/22/22/IL152879	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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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, 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 inform a supervisor prior to transporting a resident in the facility van; failed to educate staff members on safely securing a resident in the facility van and procedure to follow in case of a fall/emergency while in the facility van; failed to secure a resident with a lap belt during transport in the facility van; failed to ensure a resident was assessed by a licensed nurse prior to moving resident; and failed to perform regular maintenance checks of the wheelchair securement system. These failures resulted in V4 (CNA-Certified Nursing Assistant) improperly utilizing facility van to transport R1 to the local parade on 10/22/22. Upon return, V4 hit a bump that caused R1 to 'fly' up in her wheelchair. As R1 came down, she fell onto the floor of the van. R1 was sent to the emergency room for evaluation where she was admitted with a left intertrochanteric hip fracture	S9999		

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S9999	Continued From page 2 with excessive displacement, and a comminuted right distal tibia shaft fracture with associated fibular fracture. These failures apply to 1 resident (R1) reviewed for transport safety. Findings include: The facility's Transportation of Residents policy dated 11/1/19, documents, "Residents being transported from the facility to appointments must be done in a safe and efficient manner. An employee must obtain prior approval from his/her department director before the employee drives a vehicle for facility business purposes. An employee who drives any car for facility business purposes must exercise due diligence in so doing. The employee must comply with all traffic laws. Employee and their passengers who are driving/riding in a car on facility business purposes must wear seat belts at all times in which the car is being operated." The facility's Wheelchair Securement System Installation Manual, dated 2020, documents, "The wheelchair securement system plus compliant shoulder and pelvic belt (Occupant restraint) make a complete wheelchair securement system. Complaint shoulder and pelvic belt restraint must go across occupant's shoulder and pelvis (lap), and not be worn twisted or held away from the occupant's body by wheelchair components. We recommend using both a pelvic and shoulder belt together and not individually since it will compromise the performance of the system. The wheelchair securement system and its components MUST be regularly inspected, cleaned, and maintained-reference the Maintenance and Care section in this manual. The wheelchair securement system should not be	S9999		

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S9999	Continued From page 3 operated by anyone who does not have full comprehensive knowledge of how the system works or if the system is not working properly." The manual also documents, "Maintenance and Care: The following items should be inspected and serviced by an experienced and trained technician during the scheduled maintenance of the wheelchair securement system." The facility's Transportation Job Description, no date available, documents, "Main duties: Operates the vehicle per training." The facility's Fall/Accident/Incident Protocol, dated 2/25/21, documents, "Nursing Evaluation on all resident falls, witnessed and unwitnessed." R1's Nursing Progress note, dated 10/22/22 at 11:45 a.m., documents, "R1 was coming back to facility via facility van and staff (V4). Was reported that R1 slid out of wheelchair onto the floor of the van. R1 was brought back to facility and noted to have abrasions to bilateral lower extremities. R1 complains of right ankle pain and left leg pain 10/10 (Pain scale of 0-10). Alert and oriented. Right ankle swollen. 911 initiated." R1's Incident Investigation, dated 10/22/22, documents, "Incident occurred on transport from parade. Interview of R1: I had the upper seat belt on, but not the one going across my lap. (V4) was not speeding, but we hit a really big bump, and the cushion that I was sitting on slid forward and then I slid out under the shoulder belt and fell to the floor. (V4) got me back in my chair and brought me back to the facility. My left leg was hurting above my knee and I had a couple of scrapes on my leg from the fall. Interview with V4: When asked about the lap belt she simply stated that she did not put it on, because she could not	S9999		

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S9999	Continued From page 4 find it." The investigation also documents, "No permission to go on outing had been given by any manager. Incident occurred on transport from parade. Interview with V4: When asked who gave her permission to take R1 to the parade, V4 stated that V8 (Transport) did." V4's written statement, dated 10/22/22 at 11:45 a.m., documents, "I took (R1) to the local homecoming parade. On the way back there was a bumpy patch on the road and she slid forward out of her chair. I checked her then put her back in the chair. I noticed a skin tear on the bottom upper part of her left foot. One on top of her right foot and her right ankle looked swollen. She says her left leg hurts above the knee. I was going 25 mph." R1's Hospital Consultation, dated 10/22/22, documents, "Chief Complaint: Left hip pain. History of Present Illness/consult note: (R1) who was being transported in a van at approximately 11:30 a.m. today, 10/22/22, when the van hit a bump and (R1) came out of her wheelchair injuring her right lower leg and left hip area. The van was apparently going 25 mph and the bump caused (R1) to fall out of a pillow padded wheelchair with one safety belt, which apparently was not enough to stop her from sliding. (R1) noted significant pain to her right lower leg and left hip immediately. Radiology: X-rays of the left leg show a left intertrochanteric hip fracture with excessive displacement. X-rays of the right lower leg show a comminuted right distal tibia shaft fracture with associated fibular fracture with mild displacement." R1's Hospital Physician Dictation, dated 10/22/22, documents, "Patient's Chief Complaint is left hip pain. History of Present Illness: R1 presented to	S9999		

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S9999	Continued From page 5 the hospital due to injury sustained after falling out of a wheelchair in a vehicle earlier today. R1 states that she is wheelchair bound and had been in a van traveling to a parade. She states that she had 1 restraint on her wheelchair, but it was not enough to keep her in place. She states that the van hit a big bump, causing R1 to fall forward out of the wheelchair. She sustained injury to both of her legs. She presented to local emergency room, where she was found to have a hip fracture on the left side as well as a tibia-fibula fracture on the right side. Assessment and Plan: Left intertrochanteric fracture: Orthopedics has been consulted for surgical evaluation, plan to undergo surgical repair tomorrow. Right sided tibia-fibula fracture: Per orthopedics, will likely continue to monitor this fracture, and brace as appropriate." The facility's Serious Injury Report, dated 10/24/22, documents, "R1 traveling back in facility van from personal outing with V4 operating vehicle. V4 states that the vehicle was moving at approximately 25 mph (miles per hour) in a posted 30 mph when the van encountered a bump in the road enabling R1 to slide under applied safety harness. R1's statement concurs. R1 was evaluated by V6 (RN). Due to complaint of leg pain above the left knee and swelling to right ankle, R1 sent to ED for evaluation. Findings: Left femur fracture and right tibia/fibula fracture. Surgical repair of left hip performed on 10/23/22. Right leg cast placed on 10/23/22." V4's Personnel Disciplinary Notice, dated 10/24/22, documents, "Incident/Issue Detail: 10/22/22 Took van with (R1) on outing without permission to do so. Did not fully secure resident in van during transport. Detail Action Taken: Immediate termination."	S9999		

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On 11/7/22 at 9:00 a.m. V1 (Administrator) stated, this was a single person incident. (V4) acted alone. She didn't have permission to drive the van. Normally, we don't even do trips for individuals. We only do appointments and hospital transports. There was one other time that (V4) drove the van with (R1). (R1) wanted to go to a mural dedication ceremony that she had donated to, and I allowed it just the one time. I told (V4) I would not allow another personal trip like that for (R1) or any other residents. At the time (V4) transported (R1), the van keys were locked in the office. The nurse on duty has a key to get into the office to get those keys if needed. (V4) convinced (V5 RN) to give her keys. (V4) took (R1) to the parade, and on the way back hit a bump that caused (R1) to fall out of her wheelchair because (V4) put (R1's) shoulder harness on but not lap belt. (V4) picked (R1) up after she fell putting her back into her wheelchair, and then drove her back to the facility. (V6 RN) assessed (R1) and called 911 for her to be evaluated in the emergency room. (V4) was terminated because of this incident and for driving the facility van without permission."

On 11/7/22 at 11:35 a.m., V1 stated, "(V4's) date of hire was 4/26/22." V1 confirmed there was no documentation of V4 receiving training on the van prior to the incident.

On 11/7/22 at 10:35 a.m., V4 (CNA) stated, "Everyone knew (R1) wanted to go to the parade. I set it up to drive her to the local parade. That morning, (V5) gave me the van key that was locked in the main office. I made sure the wheelchair itself was secure, but I didn't use the lap belt. I had her arm through the shoulder belt only. When I came back from the parade, I hit some bumps and she fell out of the wheel chair. I

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S9999	Continued From page 7	S9999		

pulled over and put (R1) back in her wheel chair. The chair was secured, but she did not have the lap belt on so she slid out from underneath of it. I thought that her right ankle looked messed up. (R1) said she was hurting. So as soon as I got her in the chair, I called the facility and told them to meet me at back door. The nurse (V5) met me at the door and said to just bring her in. I told (V5) she looked like she was in pain. We put (R1) in bed. (R1) told us her left leg hurt when we put her in bed. If a resident was to fall at the facility you get the nurse to assess the resident before getting them up. However, I was never trained on what to do if a resident falls in the van. I knew I had to call the facility as soon as I got her in the wheel chair, and I told them I thought she was hurt. The nurse told me to get her back to the facility." V4 also stated, "I've drove (R1) before. We went to a mural dedication that she had donated to, and (V1) asked me to drive her to it. I think this was in June. The facility did not provide training on secure the wheel chair and what seatbelts to use. Both times I didn't use the lap belt when I transported (R1)."

On 11/7/22 at 11:00 a.m., R1 was alert sitting up in her wheelchair with her legs elevated on pillows. R1 had a cast on her right leg that started from her thigh down to her foot. R1 stated, "We were on our way back from the parade. I didn't have the belt that went across my lap on. I don't know what road she went down but it was bumpy. All of a sudden, we hit something hard. I came up out of my wheelchair, and when I came down, I fell out of my wheelchair. When I hit the ground, I knew something was wrong. My whole body hurt all over. It wasn't a good pain. (V4) pulled over, got in the back, and lifted me up into my wheelchair. I was hurting pretty bad. She (V4) probably should have called an ambulance, but

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S9999	Continued From page 8 we went back to the facility. She (V4) got me back to the facility, and they put me in bed. Not long afterwards the ambulance came, and now this", pointing at her cast. R1 stated, "(V4) drove me to the mural dedication that I was invited to back in June," pointing at an invitation that was taped to her wall that stated the ceremony was on 6/16/22." On 11/7/22 at 1:55 p.m., V9 (CNA) stated, "When, (R1) came back I helped (V4) transfer her back into her bed, but I didn't know she had fallen. When we transferred her into bed she kept saying, 'Oh' and she said it was her hip hurting." On 11/7/22 at 2:50 p.m., V3 (Maintenance Director) demonstrated the use of the van and securing a wheelchair. Once the wheelchair is in the van, the wheelchair is tethered down at four different points. Then, the lap belt is latched. The shoulder belt then comes across the resident and hooks to the lap belt. V4 confirmed that if R1's lap belt wasn't latched then the shoulder belt would not have been utilized in a safe manner either. On 11/9/22 at 9:00 a.m., V3 stated, "I'm not aware of the van needing any scheduled maintenance checks." On 11/9/22 at 11:20 a.m., V6 (RN) stated, "In the middle of my medication pass, I got a phone call from (V4), and she was in a panic. At that point, (V4) had already gotten (R1) up into her wheelchair. I didn't know the extent of what had happened. If I was (V4) I would have called 911 and asked for assistance. When she returned (V5) and (V9) assisted (R1) back into the facility. On initial inspection just looking at her when she came in the building, (R1) had a small skin tear on her foot. She was escorted to her room and	S9999		

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S9999	Continued From page 9 assisted to bed. I noticed she was having extreme amounts of pain in her right foot. She was displaying physical manifestations of extreme pain. (R1's) demeanor was just overall different she wasn't herself, she was wincing with movement, and we couldn't lift either of her legs without her crying out. At that time, I initiated 911 and contacted her on-call physician. Going 25 mph, not properly restrained, and an incident like this one occurs is going to cause someone significant injuries." V6 also stated, "I have done resident transports for this facility. I have never received any type of training regarding the facility van." On 11/9/22 at 11:40 a.m., V2 (Director of Nursing) stated, "(V4) shouldn't have been driving the van in the first place because she didn't have permission from any supervisors including myself. When (R1) fell (V4) should have immediately called 911 for assistance. She should not have gotten (R1) up into her wheelchair and then drove her to the facility." On 11/10/22 at 2:10 p.m., V8 stated that all the residents in the facility are able to be transported by the facility van. The facility's Midnight Census Report, dated 11/7/22, documents that 46 residents reside in the facility. (A)	S9999		