| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6003446 | A. BUILDING: _____ B. WING _____ | C 08/29/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HEARTLAND OF GALESBURG | 280 EAST LOSEY STREET GALESBURG, IL 61401 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| S 000 | Initial Comments<br><br>Facility Reported Incident of 8/20/18/IL105370 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br><br>300.1210b)<br>300.1210d)6)<br>300.3240a)<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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. Restorative measures shall include, at a minimum, the following procedures:<br><br>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:<br><br>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 | S9999 | **Attachment A**<br>**Statement of Licensure Violations** | |

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| S9999 | Continued From page 1<br>and assistance to prevent accidents.<br><br>Section 300.3240 Abuse and Neglect<br><br>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)<br><br>These Regulations were not met as evidenced by:<br><br>Based on observation, record review and interviews the facility failed to supervise and prevent a fall for one resident (R1) reviewed for falls. While unsupervised and wheelchair unsecured R1 rolled backwards in the facility van. This failure resulted in R1 rolling backwards and tipping over causing R1 to fall out of the wheelchair and hit R1's head, and resulted in a C5 vertebral fracture.<br><br>Findings include:<br><br>Facility investigation report for R1's fall on 8/20/18 reads, "(R1) is alert and oriented. He is here as a long term patient until V4 (family member) feels V4 can take care of (R1) at home. (R1) is very impulsive and has poor safety awareness. On 8/20/18 Maintenance Director (V3) left facility with (R1) in our van to take (R1) to (local hospital) for a scheduled follow-up CT scan of his head from previous fall with head injury on 8/2/18. Once they arrived at the hospital our staff member (V3) parked the van and went to the back and released the restraints from the wheelchair and the safety belt, (V3) then placed the resident (R1) in front of the lift door and applied his wheelchair | S9999 | | |

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| S9999 | Continued From page 2 | S9999 | | |

brakes and told (R1) to stay put so (V3) could open the lift doors. As (V3) was getting off the van, (V3) heard (R1) yell and (V3) looked back in the van and noted (R1's) feet in the air. (V3) went back in the van and (R1) stated to (V3) at that time that (R1) had released his wheelchair brakes to move the wheelchair because he thought the bar from the ramp was in the way and once (R1) unlocked the brakes the wheelchair rolled back and tipped causing (R1) to fall out of the wheelchair and hit his head."

On 8/28/18 at 10:15 A.M., V1 (Administrator) stated that it has been the facility practice to undo the securement straps from residents wheelchairs and rolling the residents in front of the ramp door prior to the ramp being lowered and ready for use. V1 stated that since this incident facility van drivers have been educated that the securement straps will not be released until the ramp is in place and the resident is ready to be rolled onto the ramp by the driver.

On 8/28/18 at 1:10 P.M., R1 was lying in the hospital bed with a neck collar on. R1 stated at the time of the fall on 8/20/18 that the driver (V3) was outside the van when R1 unlocked the wheelchair brakes. R1 stated that the van was obviously not flat because as soon as he released the breaks the wheelchair rolled quickly backwards and tipped over.

On 8/28/18 at 1:15 P.M., V4 stated that V4 has tried to tell the facility staff that R1 has some confusion at times and does not make safe decisions. V4 stated that she does not understand why V3 would have taken the safety straps off R1 before he was ready to get R1 onto the ramp. V4 stated that R1 has had a rough time in the hospital and has been in a lot of pain with

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| S9999 | Continued From page 3<br>his fractured neck.<br><br>R1's hospital radiology imaging dated 8/20/18 reads, "Fracture of the vertebral body at the level of C5 extending to the level of the vertebral foramen."<br><br>(B) | S9999 | | |