STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012017	A. BUILDING: _____ B. WING _____	11/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESIDE REHAB & HEALTHCARE	900 CENTENNIAL DRIVE EAST PEORIA, IL 61611

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S 000	Initial Comments COVID-19 Focused Infection Control Survey Complaint # 2028906/IL128579 Statement of Licensure Violations:	S 000		
S9999	Final Observations Licensure Violation 1 of 2: 300.1210b) 300.1210d)6) 300.3240a) 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. 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: 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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 requirments are not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure the safety of a resident (R3) by not utilizing the wheelchair safety belt during transport, not ensuring the safety equipment on facility van functioned properly and the facility failed to prevent a residents(R1) fall due to improper clothing wear. This failure affects two of three residents (R3, R1) reviewed for falls on the sample list of 42. This facility failure resulted in R3 falling forward out of the wheelchair landing face first on the van floor. R3 required emergency services and sustained a concussion, forehead contusion, and neck strain. Findings include: 1. R3's Undated Medical Diagnoses List included Paraplegia and Morbid Obesity. R3's Minimum Data Set (MDS) documents a Brief Interview for Mental Status score of 15 out of possible 15 (cognitively intact). R3's Emergency Room Report dated 11/3/20 documents reason for R3 visit was "patient was not secured in wheelchair in wheelchair van, and when the van slammed on the brakes, patient fell forward out of wheelchair." This same report documents injuries caused by fall of neck strain,	S9999		

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S9999	Continued From page 2	S9999		

forehead contusion and concussion without loss of consciousness.

On 11/19/20 at 11:10 AM, R3's seatbelt on the motorized wheelchair was missing the buckle on the wheelchair's left side. The safety belt strap was intact on both sides of wheelchair.

On 11/19/20 at 10:10 AM, R3 stated R3's motorized wheelchair safety belt was not buckled while riding in facility van en route to a physician's appointment. R3 stated the facility van over the lap seat belt was in place. R3 stated driver had to 'slam' on the brakes to avoid hitting another vehicle and this forced R3 to be thrown out of R3's wheelchair, landing on chest and abdomen, on van floor. R3 stated R3 was sent to emergency room after falling in facility van. R3 stated R3 did not slide under the seatbelt, but was thrown out of wheelchair because the facility van seatbelt broke and R3 was not wearing the motorized wheelchair safety belt. R3 stated the facility staff are aware of the broken seatbelt on R3's motorized wheelchair.

On 11/19/20 at 11:30 AM, V6, Transportation Aide, stated V6 remembers driving R3 to the physician's appointment on 11/3/20. V6 stated V6 buckled R3's wheelchair down to the van floor with safety straps. V6 stated R3 did not have the wheelchair seatbelt buckled because it was broken. V6 stated V6 did use the van lap seatbelt to buckle R3 in. V6 stated en route to the physician's appointment, another car pulled out in front of the facility van, causing V6 to slam on the brakes in order to avoid an accident. V6 stated R3 was thrown out of the wheelchair and landed on V6's chest/abdomen area because the facility's van safety lap belt broke. V6 stated when the emergency personnel arrived, R3 was

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S9999	Continued From page 3	S9999		

transported to the emergency room. V6 also stated that the firemen on the scene told V6 that cause of R3's fall was that the facility's van seatbelt malfunctioned.

On 11/21/20 at 2:00 PM, V19, Certified Nurse's Aide stated V19 assisted R3 to transfer from the bed to the motorized wheelchair on 11/3/20 prior to going to the physician's appointment. V19 stated R3 is alert and oriented. V19 stated R3 uses a mechanical lift for transfers. V19 stated V19 does not remember if R3's seat belt was fastened or not on 11/3/20 and that, "if (R3) said it was not fastened, then it was not fastened. (R3) would tell the truth and (R3) would know."

The facility policy titled "Standards and Guidelines: SG Transportation" revised 11/21/2017 documents the following: "Guidelines: Facility fleet vans may be utilized to transport residents for care and service needs such as dialysis, physician appointments, hospital transport, etc. Vehicles will adhere to State and Federal guidelines for safe operation of the vehicle."

2. R1's Nurse's note dated 10/14/2020 at 6:45 AM documents, "(R1) noted lying on (R1's) back in front of (R1's) toilet with CNA (V29, Certified Nursing Assistant) holding (R1's) head in her hands No shoes or socks on (R1's) feet, gait belt in place."

R1's fall report dated 10/14/20 at 6:45 AM, documents that, "(R1) was being assisted to the bathroom when (R1's) foot slipped on (R1's) pant leg and (R1) was lowered to the floor. (R1) was barefoot at the time of the fall."

On 11/23/20 at 2:43 PM, V29, CNA stated V29

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S9999	Continued From page 4 and V30,CNA were transferring R1 to the bathroom. V29 stated when R1 was inside of the bathroom, R1 went to stand up from the wheelchair and grabbed the bathroom bar to stand up. V29 stated V30 was holding the wheelchair and V29 was holding R1. V29 stated once R1 was fully standing, we (V29 and V30) went to move the wheelchair, R1 began sliding and we had to lower R1 to the floor. V29 stated R1 didn't have socks or shoes on. V29 stated R1 doesn't like to wear shoes but will wear nonskid socks. V29 stated R1 didn't have any on that day. On 11/23/20 at 2:51 PM, V30 CNA stated, "we (V30 and V29 CNA) got (R1) in the bathroom. I was behind the wheelchair and (V29) was by the (R1). (R1's) pant leg had slid underneath (R1's) foot. Now I make sure we roll (R1's) pants up. (R1) didn't have shoes or socks on either. " (A) Licensure Violation 2 of 2: 300.696a) 300.696b) 300.696c)7) 300.1210b) 300.3240a) Section 300.696 Infection Control a) Policies and procedures for investigating, controlling, and preventing infections in the facility shall be established and followed. The policies and procedures shall be consistent with and include the requirements of the Control of Communicable Diseases Code (77 Ill. Adm. Code 690) and Control of Sexually Transmissible	S9999		

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S9999	Continued From page 5 Diseases Code (77 Ill. Adm. Code 693). Activities shall be monitored to ensure that these policies and procedures are followed. b) A group, i.e., an infection control committee, quality assurance committee, or other facility entity, shall periodically review the results of investigations and activities to control infections. c) Each facility shall adhere to the following guidelines of the Center for Infectious Diseases, Centers for Disease Control and Prevention, United States Public Health Service, Department of Health and Human Services (see Section 300.340): 7) Guidelines for Infection Control in Health Care Personnel 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. Section 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 requirments are not met as evidenced by:	S9999		

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S9999	Continued From page 6 Based on interview and record review, the facility failed to implement infection control procedures to prevent the potential spread of a highly contagious disease to residents and staff. Direct care staff, while working with signs and symptoms of COVID-19 (sore throat, cough, and body aches) unnecessarily exposed residents to an infectious disease. This failure affects 28 of 36 residents (R1, R14, R15, R16, R19 though R42) reviewed for infection control on the sample list of 42. Findings include: The facility's COVID-19 Testing and Response Plan dated 6/11/20 documents, "B. Staff Symptom Screening and Testing: Consistent with the facility's infection control policies, and IDPH guidance, all HCP (Health Care Personal) (including non-staff visiting HCP, vendors, volunteers, and visitors) are screened for temperature and symptoms of SARS-CoV-2 in accordance with IDPH guidance prior to shift and at midshift. HCP who have fever of symptoms receive SARS-CoV-2 testing as described in Section III and are excluded from work pending the results of the test. HCPs who test positive for SARS-CoV-2 are excluded from work until they met return to work criteria as defined in the current IDPH guidance." The facility's COVID-19 tracking sheet documents on 11/9/20, V25 Certified Nurse's Assistant tested positive for COVID-19. This tracking sheet documents V25's symptoms as sore throat, cough, and body aches. On 11/23/20 at 2:51 PM, V25 (Certified Nurse's Assistant) CNA stated, "I started feeling bad on	S9999		

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S9999	Continued From page 7 11/7/20 which was my day off. I went back to work Monday morning (11/9/20) at 6:00 AM and they tested me around 7:30 AM or 8:00 AM. I told my nurse (V30, Registered Nurse) all morning that I didn't feel good and some of the CNAs I worked with (V28, CNA) that day. I should have called in. I worked on the 100 hall for two hours before I was sent home." On 11/24/20 at 11:22 AM, V25 stated, "When we get to work there is a paper (screening form) we have to fill out. I went onto the floor and we started getting people up for breakfast, we usually have two CNAs on the floor. We work together to get all the resident's up. I was up and down the whole hallway. We fill out our paper (screening form) ourselves, there is no one there screening us. I think I put down I was having symptoms, but I don't remember. I just don't remember a lot about that day because I was so sick. I don't even remember driving there that day." V25's Coronavirus staff checklist signed by V25 dated 11/9/20 does not document V25 had a cough, sore throat, or body aches. This checklist documents V25's temperature as 98.3 and pulse ox as 99 percent. This checklist documents no for the question, "Have you experienced shortness of breath, sore throat, fever, cough, or a combination of two: diarrhea/ chills/ repeated shaking with chills/ muscle pain/headache/ acute loss of taste or smell? On 11/24/20 at 8:48 AM, V3 ADON (Assistant Director of Nursing)/Infection Preventionist stated V25 and V28 were working the 100 wing hallway together on 11/9/20. V3 stated when she arrived at work, V28 came to her and reported V25 was working while sick. V3 stated V3 went and got V25 and performed a rapid COVID-19 test on V25. V3 stated V25 tested positive for	S9999		

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S9999	Continued From page 8 COVID-19. V3 stated it is the expectation of the staff to call off and let them know they are having symptoms. V3 stated if a staff member is having symptoms, they can rapid test them. V3 stated no staff should work with symptoms. V25's daily punch sheet dated 11/9/20 documents V25 clocked into work at 5:53 AM and clocked out of work at 8:47 AM. The facility's census sheet dated 11/9/20 documents R1, R14, R15, R16, R19 though R42 were residing on the 100 hall on 11/9/20. The facility's COVID-19 tracking sheet documents on 11/10/20, R19, R27, R28, R34, R35, R36, R38, R40, and R41 were tested for COVID-19. This sheet documents on 11/15/20 results of the 11/10/20 testing documented R19, R27, R28, R34, R35, R36, R38, R40, and R41 were positive for COVID-19. The facility's COVID-19 tracking sheet documents V28, CNA tested positive for COVID-19 on 11/16/20. The facility's COVID-19 tracking sheet documents on 11/20/20, R1, R14, R15, R30, R31, and R37 tested positive for COVID-19. On 11/24/20 at 2:55 PM, V29, County Health Department Director of Clinical Services, stated V25 would have exposed the 100 wing residents and V28 to COVID-19 and may have contributed to the residents and V28 testing positive. (A)	S9999		