STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007330	A. BUILDING: _____ B. WING _____	C 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERCREEK REHAB & HEALTHCARE CENTER	2220 STATE STREET PEKIN, IL 61554

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S 000	Initial Comments Facility Reported Incident of 11/15/24/IL181741	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 care needs of the resident. d) Pursuant to subsection (a), general	S9999		

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S9999	Continued From page 1	S9999		

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 ensure resident safety during van transportation for one (R1) of three residents reviewed for accidents in a sample of five. This failure resulted in R1 sustaining a fall and suffering from pain and fractured ribs.

Findings include:

The facility's Fleet Safety Program, undated, documents, "Safety Policy: (Named facility) has implemented a fleet management program to establish minimum safety requirements for the operation of vehicles used for company business. We are committed to providing and maintaining a safe working environment for our employees and protecting our residents and citizens of the community from injury and property loss. Your commitment to these policies and procedures are vital to building a safe driving culture within (named facility) and ensuring your own safety, the safety of others and the success of the business." This document continues to state "Employee/Driver: Comply with the requirements of this program ...Follow all safe driving rules,

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traffic regulations, and ensure driver(s) and all passengers are wearing appropriate securement device (e.g., seat belt and shoulder harness, wheelchair securement straps.) The consent form included in this Fleet Safety Program includes "As a driver of a company vehicle or a private vehicle on company business I understand that it is my responsibility to operate the vehicle in a safe manner and follow to drive defensively to prevent injuries and property damage."

R1's Quality Care Reporting Form, dated 11/12/24, documents R1 had a fall in the parking lot resulting in a small discoloration and pain to R1's chin. R1 was sent to the hospital for evaluation and treatment. Summary of event and any actions taken: "Transport staff to be educated on safety and proper transportation safety."

R1's hospital Emergency Provider Notes, dated 11/15/24, documents, "HPI (History of Present Illness): Patient reportedly fell on 11/12/24. She was reportedly in a handicap van and was being unloaded, however the lift was not up, and her wheelchair was rolled/dropped out of the van. She fell to the ground and struck her face/head and landed on her left side. She was evaluated at (named facility) who did a CT (Computed Tomography) of her head and neck but did not do imaging of her back/ribs."

R1's hospital CT Chest without Contrast, dated 11/15/24, documents, "Impression: 1. T8-T9 left rib fractures with associated small hemothorax."

On 12/11/24, at 11:43am, R1 sat in a wheelchair in a lounge area. R1 stated the following: "I was in the back of the van, and she (V7 Transportation driver) pushed me up (to the rear of the van). I guess she (V7) thought the lift was up, but it

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wasn't. I went down, fell on the ground, and broke two ribs. They sent me out to the hospital and the hospital said I had two broken ribs. I had pain when moving, but not now. There was one other resident in the van. They let him off the lift first then they never brought the lift back up. (V7) was in front of me and I was going backwards. It made me feel unsafe. They are supposed to take care of you and not you taking care of them. It scared me when I fell. My side hurt from falling on it, but I didn't know right away that I had two broken ribs until the hospital told me." R1 stated that the pain was 10/10 in the beginning and then for about two days.

On 12/11/24, at 10:30am V5 Transportation Scheduler stated the following: "(R1) was in the hospital and was picked up by (V7 Transportation Driver). I was with another resident (R5) at his appointment then we all returned together. The incident happened upon return. We got back here with both residents. (V5) was unloaded first as I lowered the ramp with (V5) on it. (V5) couldn't propel through the parking lot so I wheeled (V5) to the more even sidewalk and he was in a safe place. As I came back around to the back of the van to help with (R1) I saw (V7 Transportation Driver) wheeling (R1) to put (R1) on the ramp which was still on the ground. I tried to run to try to catch (R1) but it happened so fast. Not sure how I could have stopped it from happening. (R1) went down chair and all. (V7) was in front of (R1's) wheelchair pushing her out backwards. The wheelchair tipped and landed on its backside. (R1) was sent back to the hospital for evaluation. (R1) had redness on her shoulder blade and back, but not on her face or head. (V7) could have looked to see if the lift was up or double checked to make sure and not assume things were done. I am not sure if (V7) heard me

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say that I was taking (R5) further up to the sidewalk. I should have verified (V7) heard me and double checked the ramp was in proper place for the next resident".

On 12/11/24, at 2:07pm, V7 Transportation Driver stated the following: "We had two residents on the van, (R1 and R5) and (V5) was helping me. (R1) was in the front part of the back end of the van and (R5) was at the back. (V5) unloaded (R5) out the back using the lift. I had unhooked (R5's) wheelchair and (V5) lowered (R5) down. As (V5) lowered (R5) I went to unhook (R1) and rolled (R1) to the back. I thought (V5) had put the lift up and (V5) had not. I pushed (R1) back and was holding onto the wheelchair when I realized the lift wasn't up. That's when (R1) hit the ground hitting her head. V7 continued to state that usually the first person who lowers the lift for one resident is the one who brings it back up for the next resident because they are the one who has the controls. (R1) had said her chin hurt. (R1) was sent out to hospital. I should have checked to make sure the lift was up without assuming".

V7's current Personnel file includes but is not limited to includes "Supervisor Report of Counsel" with a date of occurrence as 11/11/24 (error - should state 11/12/24). Description of Occurrence: Resident being transported in facility van. Upon arriving at Facility, staff member went to unload resident from van and did not use proper lift equipment." V7's file also includes "Term History, Termination Date: 11/22/24. Reason: Safety Violations; Notes: Violated van safety protocols."

On 12/12/24, at 2:00pm, V1 Administrator stated the following: "(V8 Regional Director) and I discussed (R1's incident) and decided we should

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S9999	Continued From page 5 terminate (V7) and not let that happen again. It was lack of awareness. All safety protocols were in place. Human error. I was not a witness. The investigation did notate that the lift was on the ground when (R1) was wheeled out of the van. Better awareness of surroundings may have prevented the incident." (A)	S9999		