Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005490	A. BUILDING: ______ B. WING ______	C 01/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENERATIONS AT LINCOLN	2202 NORTH KICKAPOO STREET LINCOLN, IL 62656

(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
S 000	Initial Comments Complaint Investigation #1920585/IL108985 - F689 cited Complaint Investigation #1920641/IL109053 - F580, F689, F758 cited	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 300.3240a) 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 and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care	S9999	Attachment A Statement of Licensure Violations	

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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 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.

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 requirements were not met evidenced by

Based on observation, record review, and interview, the facility failed to ensure a resident was safely transported in a wheelchair utilizing foot pedals and failed to investigate falls as directed in the facility policies, for two of four residents (R2, R5) reviewed for accidents, in a sample of seven. This failure resulted in R2 being pushed in a wheelchair with no foot pedals

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attached and his stabilization boot became caught underneath him, causing a right medial meniscus (knee tendon) tear.

Findings include:

1. The facility policy, titled "Wheelchairs (5/17)" documents, "Procedure: 1. Explain procedure to resident and bring wheelchair to bedside. Lock wheels. 2. Adjust footrests. They can be folded or swung to the side for easy access to bed, toilet or tub."

The electronic medical record documents R2 was admitted to the facility 11/09/18 for therapy services following a right fibula fracture at his home.

On 1/28/19 at 9:00 a.m., R2 was laying on his bed with his right lower extremity in a stabilization boot. At that time, R2 stated, "Around New Year's (V4 - Certified Nursing Assistant) was getting ready to take me from the shower room in my wheelchair, when I asked (V4) to put the foot rests on due to my broken leg and having to wear this heavy boot. (V4) told me she didn't have time to do that, and to just lift my feet. On the way from the shower room, (V4) was pushing me pretty fast, when my feet got caught under the wheelchair, and injured my knee. I now have a torn Meniscus in my knee and might need surgery. I haven't progressed in therapy since my injury."

A Nursing Progress Note, dated 12/28/2018 at 9:00 AM, documents "CNA was pushing (R2) in his (wheelchair) back from the shower (and R2's right) leg went underneath his (wheelchair and) twisted back. (R2) does have swelling noted to the knee. (Complaint of) pain noted. No bruising

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at this time. (Medical Director) notified."

A Physical Therapy note for R2 dated 12/31/18, documents, "Improvements in activity tolerance, strength, and balance allows patient to tolerate higher levels of challenges in transfer training to reduce fall risk and maximize mobility independently. Was able to stand for a (minute) holding onto parallel bars with 50% (weight bearing) but now unable to transition sit to stand due to increased knee pain."

A Physical Therapy note for R2 dated 1/07/18 documents, "The patient is unable to stand due to increased pain with transfers in (right) knee and 50% (weight bearing) on (right lower extremity)."

A MRI (Magnetic Resonance Imaging) report for R2, dated 1/18/19 documents, "Reason for study: Pain in the right knee throughout the entire knee after twisting injury two weeks ago" and "Impression: Diffuse degenerative tearing of the lateral meniscus with undersurface tearing of the posterior horn and body of the medial meniscus."

A Correspondence Note from V6 (Advanced Nurse Practitioner), dated 1/22/19, addresses R2's MRI results and documents, "There is severe arthritic changes to the knee in all 3 compartments, greatest to the lateral aspect. Medial and lateral meniscus tears. No ligament tears. Recommend follow up with an orthopedic surgeon to discuss options."

On 1/29/19 at 10:17 am, V4 stated (on 12/28/18) she was returning R2 to his room via wheelchair. V4 stated, while pushing R2 in his wheelchair, his right foot became entangled underneath. According to V4, R2 did have his stabilization boot on his right foot when it got caught under the

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S9999	Continued From page 4 wheelchair and V4 had to get assistance from the nurse to untangle R2's foot. V4 stated R2 yelled out in pain when the incident occurred. V4 stated R2 did have footrests for his wheelchair, but she did not put them on. On 1/28/19 at 2:55 p.m., V6 stated R2 has never complained of knee pain until the incident when his foot was caught under a forward moving wheelchair. V6 stated she ordered the 1/18/19 MRI due to R2's ongoing right knee pain after that incident. V6 stated R2's MRI showed medial and lateral meniscus tears, with the medial tear being an acute injury. V6 concluded that the mechanism of R2's foot, with the stabilization boot on, being pulled under a wheelchair as it is propelling, would be consistent with this type of injury. V6 stated R2's meniscus tear has set him back in his recovery for the right fibula fracture and hindered his physical therapy and timeframe for discharge. 2. The facility "Fall Reduction Program (7/18)" policy documents, "It is the policy of this facility to have a Fall Reduction Program that promotes the safety of residents in the facility. The program's intent is to assist clinical staff in determining the needs of each resident through the use of standard assessments, the identification of each resident's individual risks, and the implementation of appropriate interventions, supervision, and/or assuasive devices deemed appropriate" and "In the even a fall incident occurs, nursing staff will complete an assessment of the resident and obtain the facts surrounding the fall, and report findings to the resident's physician and responsible party and document findings and notification within the resident's clinical record. 7. Post fall monitoring shall be completed by the nursing staff every shift for 72 hours and findings	S9999		

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documented within the clinical record. 8. Attempts shall be made to implement new or modified interventions as needed to enhance safety and consistent with root cause analysis; new interventions to be communicated to the facility staff through revision of resident care plan and profile to maintain continuity of care."

The facility policy, titled "Post Fall Investigation (5/17)," documents, "It is the policy of this facility to investigate falling incidents as part of the Quality Assurance Process in efforts to determine possible causative factors and to develop an individualized prevention plan in attempts to prevent further occurrences. Procedure: 1. A Post Fall Investigation form will be completed by staff within seventy two hours of the occurrence. 2. After the completion of the form, information will be reviewed to determine, if possible causative factors and include interventions that are currently being used and those interventions that will be implemented as a result of the investigation."

An Event Report, dated 12/29/2018 at 9:00 PM, by V13 (Licensed Practical Nurse), documents R5 fell in his room from his bed, did not complain of pain and no injury was noted; however, a Witness Report by V15 (Licensed Practical Nurse), dated 12/29/18 at 9:15 PM, documents "(R5) was laying between bed and wall (with) heater on his left side. (R5) stated that he hit his head, left arm & leg on the floor and that they hurt."

An Event Report, dated 1/01/19 at 8:05 PM, by V13, documents R5 fell in his room from his bed and sustained "redness, bruising and bump" to right wrist/elbow.

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S9999	Continued From page 6 The Electronic Medical Record contains no corresponding Resident Progress Notes detailing any information regarding the 12/29/18 or 1/01/19 fall. On 1/29/19 at 2:05 pm, V1 (Administrator) stated, she did not have investigations, which are to be completed by V1 or V2 (Director of Nursing) for R5's falls, as the nurse who was caring for R5 at the time of each incident (V13) did not notify Administrative Staff of the falls, so an investigation could be initiated and potential cause determined. V1 concluded that V13 was reprimanded for not following the facility "Fall Reduction Program." (B)	S9999		