STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145430	A. BUILDING _____ B. WING _____	12/13/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN NURSING HOME	**1507 7TH STREET LINCOLN, IL 62656**

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F 465	Continued From page 6 Based on the Resident census and conditions form, this has the potential to affect all 93 residents in the facility dated 12/13/13.	F 465		
F9999	FINAL OBSERVATIONS Statement of Licensure Violations 300.610a) 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 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:	F9999		

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F9999	Continued From page 7 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. These Regulations were not met as evidenced by: Based on observation, interview and record review, the facility failed to develop and implement policies and procedures for educating and training staff on the proper safety interventions and precautions to use when transporting residents in the facility vehicles. This failure resulted in head and chest injuries during transport to the local hospital for one resident (R25) of three reviewed for accident/incidents in a sample of 19. Findings include: A facility Incident/Accident Report dated 10/15/13 indicated that R25 was transported to the local hospital on 10/14/13 at approximately 7:30 PM via the facility bus for direct admission to the	F9999		

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hospital for treatment of CHF (Congestive Heart Failure.) The report stated that when the bus arrived at the hospital, R25's wheel chair was noted tipped back with the resident's head against the lift; and when the bus came to a stop, the resident and wheelchair fell forward. The report stated that R25 sustained a laceration to the back of the head, and complained of chest pain. The report stated that R25's hospital EKG (electrocardiogram) was normal and R25's hospital chest x-ray indicated a fractured sternum.

The hospital Emergency Physician Record for R25 dated 10/14/13 indicated under the Clinical Impression section that R25 sustained a scalp abrasion and a "sternal fracture with intractable (unresolvable) CP (chest pain)."

E2 (Director of Nursing) stated on 12/6/13 at 10 AM, with regards to R25's accident on 10/14/13 and E2's investigation into the matter, that R25 sustained the sternal fracture from impact with the bus's shoulder restraint belt.

E4 [Licensed Practical Nurse (LPN)] stated on 12/11/13 at 10:10 AM that on the evening of 10/14/13, E4 received a physician order for a direct hospital admit for possible dialysis for R25. E4 said that E4 found a Certified Nurse Aide (CNA) E7, who had previously driven the facility van, to drive R25 over to the hospital. E4 said that E4 could not find the keys to the facility van in the 100 wing medication cart, where the keys for the facility vehicles are kept. E4 said that only the keys for the facility's small bus were found, so E4 told E7 to drive the bus that evening.

E4 also stated that prior to the accident with R25,

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non-emergency transport was done via family car or facility van. E4 said that since the accident, now all medically related transports are done by ambulance. E4 said that shortly after R25's accident in the bus, E2 (Director of Nursing) gave E4 verbal counseling for allowing staff to use the facility bus for transport. E4 said that E4 has worked at the facility for over a year now, and no one ever instructed E4 that floor staff were not allowed to drive the facility bus.

E7 (CNA) stated on 12/6/13 at 1:30 PM with regards to the transport of R25 last October, that CNA E5 loaded R25 in the bus and strapped R25 in via the seat belt and four wheel chair restraining straps in the back of the bus. E7 said E5 then went back into the facility. E7 said CNA E6 then rode along with R25 in the back of the bus. E7 said when E7 was driving the bus around the curve in the circle drive of the hospital, E7 heard a crash. E7 said E6 then told E7 that R25 hit his head and was bleeding. E7 said that E6 and E7 could not get the bus's mechanical wheelchair lift to work to unload R25, so hospital staff responded. E7 said that hospital staff then transferred R25 off the bus strapped to a back board.

E7 said that E7 had never driven the facility's small bus before, only the facility van once. E7 said that after R25's accident, the facility's policy now prohibits any staff other than activity staff or Transport Aide E9 to drive the van or small bus.

E7 stated on 12/11/13 at 2:10 PM that E7 has worked at the facility for about two years; and E7 never received training on driving the van or bus or restraining residents in these vehicles.

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E6 (CNA) stated on 12/6/13 at 1:45 PM, in regards to R25's accident, that E5 showed E6 and E7, who drove the bus, how to use the lift on the bus while loading R25 inside. E6 said E5 then restrained R25's wheelchair to the floor, while E6 secured the shoulder belt around R25. E6 said that E5 then left and went back into the facility. E6 stated that when the bus went around the curve in the driveway at the hospital, R25's wheelchair tilted back with the front wheels lifting off the floor. E6 said the back of R25's head hit the lift platform, and afterwards, R25 said that his chest and head hurt. E6 said that there was a small cut on the back of R25's head less than one centimeter, which bled for a short time.

E6 said that E6 never helped with a resident transport before, and since the accident, facility policy allows only activity staff and E9 to do resident transports.

E5 (CNA) stated on 12/6/13 at 12:40 PM that she loaded R25 and his wheelchair in the back corner of the bus and locked the wheels of the chair. E5 said that E5 also tightly applied the floor straps with hooks to each of the four wheels of the chair, before exiting the bus.

On 12/6/13 at 2 PM, E6, with the surveyor and E1 (Administrator) present, pointed out where R25 and his chair were sitting in the back right corner of the bus on the night of the accident. E6 showed the spot on the bottom platform of the lift, which was in the vertical, folded position, where R25's head had struck it. E6 said that rather than facing forward in the bus, R25 was placed sideways in the bus by E5, with the back of R25 near the folded lift platform.

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F9999	Continued From page 11 E1 stated at 2:10 PM on 12/6/13 that prior to the accident with R25 in October, the facility had no written policy for staff to abide by for resident transports. E1 said that after the accident, a new written policy was put in force requiring that facility bus and van drivers have a JO2 endorsement on their driver's license policy. E1 said that the new policy also outlines procedures for securing residents inside the vehicles as well. (B) 300.670 c)1) 300.670 c)2) 300.670 c)3) 300.670 d) 300.670 e) 300.670 f) 300.670 g) Section 300.670 Disaster Preparedness c) Fire drills shall be held at least quarterly for each shift of facility personnel. Disaster drills for other than fire shall be held twice annually for each shift of facility personnel. Drills shall be held under varied conditions to: 1) Ensure that all personnel on all shifts are trained to perform assigned tasks;	F9999		

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F9999	Continued From page 12 2) Ensure that all personnel on all shifts are familiar with the use of the fire-fighting equipment in the facility; 3) Evaluate the effectiveness of disaster plans and procedures. d) Fire drills shall include simulation of evacuation of residents to safe areas during at least one drill each year on each shift. e) There shall be special provisions for the evacuation of physically handicapped persons, including those who are hearing or sight impaired. f) Where the welfare of the residents precludes an actual evacuation of an entire building, there must be drills involving the evacuation of successive portions of the building under such conditions as to assure the capability of evacuating the entire building with the personnel usually available, should the need arise. g) A written evaluation of each drill shall be submitted to the facility administrator and shall be maintained for one year. These Regulations were not met as evidenced by: Based on interview and record review, facility failed to have a policy for disaster preparedness when they failed to: Conduct a third shift fire drill in the second quarter and could not provide two disaster drills for the year.	F9999		

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F9999	Continued From page 13 Findings Include: On 12/13/2013 in AM E1/Administrator stated that they don't have a Disaster Preparedness policy. E1 stated the facility follows the Illinois regulations. On 12/13/13 at 9:45AM., E1/Administrator stated that E10/ Life Safety Coordinator was two weeks late on getting the third shift fire drill done. On 12/11/13 at 3:05 E1/ Administrator stated that the second disaster drill could not be located. This failure has the potential to affect all 93 residents living at the facility. (AW)	F9999		