STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. BUILDING _____ B. WING _____	C 06/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

(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) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint Investigation #1613128 / IL86063 #1613153 / IL86092 A partial-extented survey was conducted	F 000		
F 224 SS=K	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure resident incidents were investigated to prevent recurrence. The facility repeatedly failed to investigate and record events where lift slings failed during transfers. The facility failed to ensure policies and procedures for falls, accident reporting, and manufacturer's guidelines were followed. The facility failed to ensure the structural integrity of the lift slings before using a sling during transfers with mechanical lifts. These failures resulted in a sling breaking while R1 was being transferred on June 6, 2016. R1 fell and sustained fractures to both her lower extremities and was hospitalized on June 6, 2016. R1's fall contributed to her death on June 10, 2016. The neglect existed between May 11, 2016 and	F 224		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. BUILDING _____ B. WING _____	C 06/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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) COMPLETION DATE
F 224	Continued From page 1	F 224		

June 17, 2016.

An Immediate Jeopardy began on May 11, 2016 at 3:00 PM. The Administrator was notified of the Immediate Jeopardy on June 15, 2016 at 9:15 AM. While the immediacy was removed on June 17, 2016 at 10:00 AM the facility remains out of compliance at Severity Level 2. Additional time is needed to monitor and evaluate the effectiveness of the revised policies and procedures to ensure their implementations

This applies to 4 of 5 residents (R1, R2, R3, R4) reviewed for policies and procedures in the sample of 5.

The findings include:

1. On June 9, 2016 at 1:15 PM, E12 Certified Nursing Assistant (CNA) stated during R1's mechanical lift transfer, the "black loop (on the lift sling) snapped and [R1] went down."

R1's June 6, 2016 Incident Report shows R1 was transferred to the hospital after the fall. On June 8, 2016 at 3:30 PM, Z2 (hospital RN) stated R1 broke her left leg near her hip, and broke her right leg near her knee. On June 13, 2016 at 10:15 AM, Z2 (family member) stated R1 died on June 10, 2016. On June 14, 2016 at 8:30 AM, Z5 (hospital physician) stated R1's fall led to her fractures, which is why R1's condition deteriorated, and the injuries contributed to her demise.

On June 9, 2016, at 12:30 PM, E1 (Administrator) showed R1's torn lift sling to surveyors. The lift sling had four loops on each of its four corners that are used for attachment to the mechanical lift

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. BUILDING _____ B. WING _____	C 06/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

(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) COMPLETION DATE
F 224	Continued From page 2	F 224		

(one corner each to support a patient's arms, and one corner each to support a patient's legs.) One of the black support loops on the sling was ripped in half where the loop attached to the lift bar. On June 9, 2016 at 12:30 PM, E2 (Administrative Assistant/RN) explained the torn loop corresponded to R1's left leg during the transfer.

On June 9, 2016 at 12:30 PM, E1 examined the green support loops on the sling used during R1's June 6, 2016 transfer. Green fabric was missing from the surface of the green loops and the black threads underneath the green surface were exposed and flexible. E1 stated lift slings should be pulled from the floor if they look like they are frayed, or tearing, or do not look sturdy. On June 14, 2016 at 8:45 AM, E1 stated she would have pulled R1's mechanical lift sling on June 5, 2016 (prior to R1's fall) if she had seen the condition of the green loops then.

On June 9, 2016 at 1:05 PM, E5 (CNA Supervisor) stated the last time she checked the lift slings before R1's fall on June 6, 2016, was "probably three weeks ago." On June 14, 2016 at 2:40 PM, E2 (Administrative Assistant) stated there is no specific policy for the lift slings.

On June 14, 2016 at 1:35 PM, E20, (CNA) stated a lift sling broke on R1 during a mechanical lift transfer shortly after she was admitted to the facility. On June 14, 2016, at 2:15 PM, E21 (CNA) verified R1's lift sling previously broke during a transfer not long after she was admitted. R1's Face Sheet shows she was admitted on April 27, 2016.

2. On June 10, 2016 at 1:45 PM, E15 (CNA) stated she and E17 (CNA) were transferring R2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. BUILDING _____ B. WING _____	C 06/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

(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) COMPLETION DATE
F 224	Continued From page 3	F 224		

with the mechanical lift when the center of a lift sling loop ripped. R2 fell onto the bed. On June 14, 2016 at 9:45 AM, E17 verified R2 fell onto the bed when the sling loop ripped. The date of the occurrence cannot be verified because no incident report was generated and there is no documentation in the nursing notes describing the incident.

On June 14, 2016 at 11:00 AM, E10 (CNA) stated she was present for a different instance where R2's sling broke during a transfer, this time on May 28, 2016. E10 stated she was transferring R2 from the wheelchair into the bed with E20 (CNA). On June 14, 2016 at 1:35 PM, E20 verified R2's sling ripped while being transferred to her bed.

3. On June 10, 2016 at 10:30 AM, E16 (CNA) stated one of the lift sling loops snapped while R4 was being transferred. E16 stated she thought the incident occurred on May 11, 2016. On June 14, 2016 at 12:45 PM, E9 (CNA) stated he entered R4's room and E16 and E5 (CNA Supervisor) were transferring R4, and he saw R4's sling loop snap during the transfer.

On June 9, 2016 at 11:45 AM, E11 (Restorative Nurse) stated she tracks the facility incident reports for falls or other incidents that occur that are "out of the norm." E11 stated she has no incident reports showing any residents fell from a lift sling. E11 stated an incident report should be generated even if someone is in a mechanical lift sling and falls only inches. On June 10, 2016 at 11:00 AM, E11 stated if an occurrence is out of the ordinary and not consistent with a resident's care plan, an incident report should be completed. E11 added if an occurrence is a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. BUILDING _____ B. WING _____	C 06/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

(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) COMPLETION DATE
F 224	Continued From page 4	F 224		

"near-miss" and the resident has no injuries, there should be an incident report for that, too.

4. On June 9, 2016 at 10:15 AM, R3 was in his wheelchair with a mechanical lift sling placed under him. The sling is left under the resident after the resident is transferred. The blue support loop on the sling near his right shoulder was torn.

There were no documented incident/fall reports for R1's first fall, R2's falls & R4's fall. There was no documentation in the nurse's notes regarding these incidents. R1's fall report (dated June 6, 2016) does not show R1's fall was the result of a torn sling.

The facility's May 2016 Resident Accident/Incident Reporting policy shows "1.) An accident/incident report must be completed by the nurse on duty at the time of the accident/incident. A descriptive summary of the incident must be noted in the Nurse's Notes in the resident's chart." The policy shows "3.) Reports must be forwarded to the Restorative nurse or designee upon initial completion for investigation and follow-up ..."
The facility's October 2015 Fall Policy "Purpose" section shows "Supervisors are required to investigate all incidents promptly for the purpose of preventing repeated incidents. The Nurse's Notes should contain complete information regarding the incident."

The facility's October 2015 Fall Policy "Procedure" section shows "2. B. Nursing personnel will timely complete an incident report ..." Section C. shows "Each fall will be reviewed by the Interdisciplinary Team (IDT) during daily IDT meeting or sooner. Root cause/extrinsic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. BUILDING _____ B. WING _____	C 06/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

(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) COMPLETION DATE
F 224	Continued From page 5	F 224		

factors of the fall will be identified by IDT at this time. Care plan interventions to further prevent falls will be discussed and implemented, and the "IDT Post Fall Evaluation" form will be completed. In the lift sling Owner's Operator and Maintenance Manual, Patient Slings, (dated 2008), Section I, General Guidelines, (page 5) shows "In case of damage, do not use the equipment."

Section I, General Guidelines, (on page 6) includes a "WARNING" that shows "After each laundering (in accordance with instructions on the sling), inspect sling (s) for wear, tears, and loose stitching. Bleached, torn, cut, frayed, or broken slings are unsafe and could result in injury. Discard immediately." Under "Care" (page 6), the manual shows "Air dry or dry at low temperature. Inspect with each use."

On June 9, 2016 at 12:30 PM, E1 stated [E5] checks the slings in the mornings either weekly or monthly, and laundry looks at them, too. On June 9, 2016 at 3:00 PM, E14 (Laundry Aid) stated he usually has to dry the slings in the dryer at least once each week and he doesn't inspect the lift slings. On June 14, 2016 at 9:55 AM, E14 stated he sets the dryer on "C" setting to dry the slings. E14 added it depends on the load, but one dryer cycle doesn't dry the slings. On June 14, 2015 at 9:50 AM, E22 (Laundry and Environmental Supervisor) stated "C" setting on the clothes dryer is 160 degrees Fahrenheit.

The Special Notes Section on page 4 categorizes the word "WARNING" as a "signal word," which is defined as "Warning indicates a potentially hazardous situation, which, if not avoided, could result in death or serious injury."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. BUILDING _____ B. WING _____	C 06/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

(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) COMPLETION DATE
F 224	Continued From page 6	F 224		

Based on interview and record review the surveyor confirmed that the facility took the following actions to remove the Immediate Jeopardy:

1. A team of administrative nurses have inspected and replaced all full-body lift slings for the facility.
2. Policies for Sling Care have been developed to focus on laundering, CNA inspection prior to every use, removal from service and unusual occurrences.
3. Administrative Nurses reviewed and revised the Accident and Incident policy and procedure with focus on unusual occurrences, definition of fall, documentation and reporting regardless of injury or not.
4. Direct care staff will be in-serviced on the sling care policy and procedure by Manufacturer Representative and Regional Administrator/Nurse on 6/16/16.
5. Direct care staff and Nursing staff will be in-serviced on policy and procedures for reporting and documenting unusual occurrences and definition of fall.
6. All staff will be in-serviced prior to providing care in the facility including new employees upon hire and annually.
7. Quality Assurance Root cause analysis was initiated post incident and completed on 6/14/16. QA review of unusual occurrences will be completed post incident and reported to the Safety committee and QAPI committee.
8. QA Checks will be completed daily and reviewed by safety committee monthly. The trends and concerns reported to the QAPI committee quarterly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. BUILDING _____ B. WING _____	C 06/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

(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) COMPLETION DATE
F 323	Continued From page 7	F 323		
F 323 SS=K	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure staff performed safe transfers while using a resident sling with a mechanical lift. The facility failed to have a system in place to ensure staff did not transfer resident with a worn out or damaged sling. The facility failed to ensure the integrity of the sling before staff used the sling during a resident transfer with a mechanical lift. These failures resulted in a sling breaking while R1 was being transferred with the mechanical lift. R1 sustained fractures to both her lower extremities and was hospitalized on June 6, 2016. R1's fall contributed to her death on June 10, 2016. The Administrator was notified of an Immediate Jeopardy on June 15, 2016 at 9:15 AM. The Immediate Jeopardy began on May 11, 2016 at 3:00 PM. While the immediacy was removed on June 17, 2016 at 10:00 AM the facility remains out of compliance at Severity Level 2. Additional time is needed to monitor and evaluate the effectiveness of the revised policies and procedures to ensure their implementations.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. BUILDING _____ B. WING _____	C 06/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

(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) COMPLETION DATE
F 323	Continued From page 8	F 323		

This applies to 4 of 5 (R1, R2, R3, R4,) residents reviewed for safe transfers in the sample of 5.

The findings include:

1. On June 9, 2016 at 1:15 PM, E12 Certified Nursing Assistant (CNA) stated during R1's mechanical lift transfer, the "black loop (on the lift sling) snapped and [R1] went down." E12 added "as far as I remember she went straight to the floor" and "it would be impossible to catch her when there's that much force." On June 10, 2016 at 2:00 PM, E13 (CNA) verified the sling loop ripped during R1's transfer on June 6, 2016.

R1's June 6, 2016 Incident Report shows R1 was transferred to the hospital after the fall. On June 8, 2016 at 3:30 PM, Z2 (hospital RN) stated R1 broke her left leg near her hip, and broke her right leg near her knee. On June 13, 2016 at 10:15 AM, Z2 (family member) stated R1 died on June 10, 2016. On June 14, 2016 at 8:30 AM, Z5 (physician) stated R1's fall led to her fractures, which is why R1's condition deteriorated, and the injuries contributed to her demise.

On June 9, 2016, at 12:30 PM, E1 (Administrator) showed R1's torn lift sling to surveyors. The lift sling had four loops on each of its four corners that are used for attachment to the mechanical lift (one corner each to support a patient's arms, and one corner each to support a patient's legs.) One of the black support loops on the sling was ripped in half where the loop attached to the lift bar. On June 9, 2016 at 12:30 PM, E2 (Administrative Assistant/RN) explained the torn loop corresponded to R1's left leg during the transfer.

On June 9, 2016 at 12:30 PM, E1 examined the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. BUILDING _____ B. WING _____	C 06/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

(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) COMPLETION DATE
F 323	Continued From page 9	F 323		

green support loops on the sling used during R1's June 6, 2016 transfer. Green fabric was missing from the surface of the green loops and the black threads underneath the green surface were exposed and flexible. E1 stated lift slings should be pulled from the floor if they look like they are frayed, or tearing, or do not look sturdy. On June 14, 2016 at 8:45 AM, E1 stated she would have pulled R1's mechanical lift sling on June 5, 2016 (prior to R1's fall) if she had seen the condition of the green loops then. E1 also stated, it is eveyone's job to ensure a sling is in good repair before using.

On June 14, 2016 at 1:35 PM, E20 (CNA) stated R1's June 6, 2016 fall was actually the second time a lift sling broke while transferring R1. E20 stated the first time R1's sling "just snapped" was during a transfer with E21 (CNA). On June 14, 2016, at 2:15 PM, E21 verified R1's lift sling broke during a transfer shortly after she was admitted, but he could not remember the date. (R1's Face Sheet shows she was admitted to the facility on April 27, 2016.)

2. On June 10, 2016 at 1:45 PM, E15 (CNA) stated she and E17 (CNA) were transferring R2 with the mechanical lift when the center of a lift sling loop ripped. R2 fell onto the bed. On June 14, 2016 at 9:45 AM, E17 verified R2 fell onto the bed when the sling loop ripped. On June 9, 2016 at 1:55 PM, E2 (Director of Nursing) stated it was reported to her that R2's full-body mechanical lift sling had broken the same way R1's lift sling did on June 6, 2016. E2 stated no incident report was written for R2 because R2's sling broke before R2 had really gotten off the bed and she had no injuries. When asked what staff can learn from "near-miss" occurrences, E2 replied "they

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. BUILDING _____ B. WING _____	C 06/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

(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) COMPLETION DATE
F 323	Continued From page 10	F 323		

teach us how to prevent them."

On June 14, 2016 at 11:00 AM, E10 (CNA) stated she was present on May 28, 2016 for a second instance where R2's sling broke during a transfer. E10 stated she was transferring R2 from the wheelchair into the bed with E20 (CNA). E10 stated R2 was not fully off her wheelchair and she and E20 used a stand-up lift to transfer R2 into bed. E10 stated the lift sling ripped on the fabric where the support loops are sewn to the main part of the sling. On June 14, 2016 at 1:35 PM, E20 verified R2's sling ripped while being transferred to her bed. On June 14, 2016 at 9:00 AM, Z6 (family member) stated "it happened once, and then it happened around two weeks later." On June 9, 2016 at 10:30 AM, R2 stated the sling broke twice during a transfer and she gets nervous and anxious during transfers because of the occurrences.

3. On June 10, 2016 at 10:30 AM, E16 (CNA) stated one of the lift sling loops snapped while R4 was being transferred. E16 stated she thought the incident occurred on May 11, 2016. On June 14, 2016 at 12:15 PM, E16 stated R4 was being transferred out of the bed into the wheelchair. E16 stated the transfer was almost complete and R4 was a few inches above his wheelchair in the air when the loop closest to the sling snapped. E16 stated R4 landed "a little sideways" in his wheelchair. On June 14, 2016 at 12:45 PM, E9 (CNA) stated he entered R4's room while E16 and E5 were transferring R4, and he saw R4's lift sling loop snap during the transfer. On June 10, 2016 at 10:35 AM, E18, Licensed Practical Nurse (LPN) verified CNAs reported that R4's sling loop snapped and he fell into his wheelchair during a transfer with the mechanical lift.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. BUILDING _____ B. WING _____	C 06/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

(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) COMPLETION DATE
F 323	Continued From page 11	F 323		

4. On June 9, 2016 at 10:15 AM, R3 was in his wheelchair with a mechanical lift sling placed under him. The blue support loop on the sling near his right shoulder was torn.
On June 9, 2016 at 1:05 PM, E5 (CNA Supervisor) stated the last time she checked the lift slings before R1's fall on June 6, 2016, was "probably three weeks ago." On June 9, 2016 at 3:00 PM E5 and surveyors checked slings that were out on the floor for resident use. E5 removed 4 other mechanical lift slings that showed signs of damage or wear that were in use to transfer residents.

In the Owner's Operator and Maintenance Manual, Patient Slings, (dated 2008), the Special Notes Section (page 4) categorizes the word "WARNING" as a "signal word," which is defined as "Warning indicates a potentially hazardous situation, which, if not avoided, could result in death or serious injury." The manual shows in Section I, General Guidelines, (page 5), "In case of damage, do not use the equipment." Section I, General Guidelines, (page 6) includes a "WARNING" that shows "After each laundering (in accordance with instructions on the sling), inspect sling (s) for wear, tears, and loose stitching. Bleached, torn, cut, frayed, or broken slings are unsafe and could result in injury. Discard immediately."

Based on interview and record review, the surveyor confirmed the facility took the following actions to remove the Immediate Jeopardy:

1. A team of administrative nurses have inspected and replaced all full-lift slings for the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. BUILDING _____ B. WING _____	C 06/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

(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) COMPLETION DATE
F 323	Continued From page 12	F 323		

2. Policies for Sling Care have been developed to focus on laundering, CNA inspection prior to every use, removal from service, and unusual occurrences. Slings will be removed from service immediately by any staff member who identifies any issue with the sling and turned in to administrative nurse.
3. All laundry staff have been ins-serviced on Sling Care Policy and Procedure. All slings are being laundered per manufacturer guidelines. Slings will be removed from service by any staff member who identifies any issue with the sling and turned in to administrative nurse.
4. Direct care staff will be in-serviced on the sling care policy and procedure by Manufacturer Representative and Regional Administrator/Nurse, including that slings will be removed from service immediately by any staff member who identifies any issue with the sling and turned in to the administrative nurse, and CNA inspection prior to every use.
5. All staff will be in-serviced prior to providing care in the facility including new employees upon hire and annually. Slings will be removed from service immediately by any staff member who identifies any issue with the sling and turned in to administrative nurse.
6. Quality Assurance Root cause analysis was initiated post incident and completed.
7. Quality Assurance tools have been developed to ensure proper sling inspection and laundering of slings. Checks will be completed daily by charge aids and reviewed by safety committee monthly. The trends and concerns reported to the QAPI committee quarterly.