STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003446	A. BUILDING: _____ B. WING _____	C 05/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND OF GALESBURG	280 EAST LOSEY STREET GALESBURG, IL 61401

(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 Facility reported Incident of 4/26/19/IL 111791	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 which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. 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	S9999	Attachment A Statement of Licensure Violations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003446	A. BUILDING _____ B. WING _____	C 05/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND OF GALESBURG	280 EAST LOSEY STREET GALESBURG, IL 61401

(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
S9999	Continued From page 1	S9999		

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 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 Regulations were not met as evidenced by:

Based on observation, record review and interview, the facility failed to ensure adequate staff were present while conducting a mechanical lift transfer for one resident (R1) reviewed for falls. This failure resulted in R1 sustaining a fall while in the mechanical lift and dislocating R1's left hip subsequently requiring transport to the local hospital and moderate sedation to reduce

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003446	A. BUILDING: _____ B. WING _____	C 05/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND OF GALESBURG	280 EAST LOSEY STREET GALESBURG, IL 61401

(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
S9999	Continued From page 2 R1's left hip. Findings include: The facility's Mechanical Lift policy (4/2019) documents the following: "To move immobile or obese patients for whom transfer poses potential for staff or patient injury. Verify transfer assist needed per Kardex. Obtain additional assistance and needed equipment as indicated. Use of a mechanical lift requires a second caregiver. Using the hand control, slowly raise the patient to a standing position. If at any time the patient is unable to assist with the transfer and bear weight on lower extremities, return the patient to the sitting position on the chair or bed." The facility's mechanical lift manufacturer Guide (7/2016) documents the following: "Intended use: (Mechanical Lift) is a standing and raising aid for short transfers e.g. raising from bed and transfer to wheelchair, or from wheelchair to toilet. (Mechanical Lift) is also suitable for walking training when the footboard and kneepad are removed. (Mechanical Lift) is intended to be used in hospitals, nursing homes or other health care facilities for the different category of residents/patients. Category C, where the resident/patient: Sits in a wheelchair; Is able to bear weight on at least one leg; Has some trunk stability; Is dependent on the caregiver in most situations; And needs mobility-maintaining standing exercise. If possible, the patient should then hold on to the Patient Support arms with one or both hands. The patient is then ready to be lifted. If the patient is able to offer some assistance when standing this may be beneficial to patient confidence and muscular exercise. Patients who can only hold on with one hand, (those who have suffered a 'stroke', for example)	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003446	A. BUILDING: _____ B. WING _____	C 05/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND OF GALESBURG	280 EAST LOSEY STREET GALESBURG, IL 61401

(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
S9999	Continued From page 3	S9999		

may still be lifted by using the (Mechanical Lift). The patient may just rest the unusable arm on the Arc- Rest or hold it across their chest, and rest their elbow on the end of the Arc- Rest, while their usable hand holds the handgrip in the normal way."

R1's current electronic Medical Diagnoses list documents the following diagnoses: Aftercare following joint replacement surgery, Need for assistance with personal care, Muscle weakness, Morbid obesity, Fracture of unspecified part of neck of left femur, and Presence of left artificial hip joint.

R1's Admission/Readmission Screen (4/25/19) documents R1 was admitted to the facility on 4/25/19 from an acute care hospital following surgery for a left hip fracture. This form documents R1 is able to communicate R1's needs and identifies R1 as at risk for falls.

R1's Patient Transfer Screening Worksheet (4/25/19) documents R1 is to utilize a Sit to stand mechanical transfer device with appropriate weight capacity.

R1's Incident Report (4/26/19) documents the following: "(R1) was being transferred from her wheelchair with (mechanical lift) to the bathroom and fell to the floor, on her buttocks. (R1) was assessed, range of motion was normal. (R1) complaining of discomfort to the left hip but no more than usual. (R1) then was lifted up by four staff members and gait belt, then (R1) stated, 'It's really starting to hurt.' Pain medication was given and (V6, R1's Physician) called to send to (local hospital). On 4/26/19 at 3:00 PM, V3 (Certified Nursing Assistant/CNA) went to answer (R1)'s call light. (R1) told (V3) she had to use the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003446	A. BUILDING: _____ B. WING _____	C 05/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND OF GALESBURG	280 EAST LOSEY STREET GALESBURG, IL 61401

(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
S9999	Continued From page 4	S9999		

bathroom so (V3) hooked (R1) up to the mechanical lift to assist (R1) to the bathroom. As (V3) was lifting the patient, the patient let go of the lift handles and knees buckled causing (R1) to fall to the ground on her buttocks."

R1's local Emergency Department report (4/26/19) documents R1's admitting diagnosis was Unspecified dislocation of the left hip. This report also documents the following: "(R1) had a dislocation of her left hip. Moderate sedation and closed reduction of (the) left hip was performed and (R1) tolerated well."

R1's Statement (4/30/19) regarding the 4/26/19 fall incident documents the following: "(V3, CNA) came in to help me to the bathroom. (V3) was getting me ready. I (R1) said, 'Do you need two aides?' (V3) said, 'No we will make it with one.' We started to go and my hands came off the lift and I went straight down (to the floor) on my bottom. The sling was still on me but loose."

V3's Statement (4/29/19) regarding the 4/26/19 fall incident documents the following: "I (V3) went to answer (R1)'s call light. (R1) stated she needed to use the bathroom. I went to get the (Mechanical sit to stand lift) to transfer (R1) from her wheelchair. I put the sling around her for the lift. I couldn't/didn't look for assist(ance) because I was trying to just get (R1) in the bathroom so she didn't have to wait. I had transferred her the day before with the lift and assist and (R1) did not hold on to it very well but I don't remember if I told my nurse. I started to lift (R1) with the lift and as I kept going up with the lift, (R1) started to slide down out of the sling and I couldn't get the wheelchair under her. (R1) was half way up with the (mechanical lift). I was unable to get the wheelchair under (R1) and (R1) was still in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003446	A. BUILDING: _____ B. WING _____	C 05/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND OF GALESBURG	280 EAST LOSEY STREET GALESBURG, IL 61401

(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
S9999	Continued From page 5	S9999		

sling with Velcro strapped around her when her bottom hit the ground with her legs out in front of her with her feet on the machine."

On 5/6/19 at 1:00 PM, R1 was sitting in R1's wheelchair watching television. R1 stated, "They dropped me over there (pointing to a nearby area in R1's room). (V3) did not have me fastened in well enough and I fell. It just happened so fast." R1 stated that prior to that fall, there had been two Certified Nursing Assistants transferring R1 utilizing the mechanical lift and that it was only V3 transferring R1 when R1 fell.

On 5/7/19 at 1:10 PM, V7 (Certified Nursing Assistant) and V8 (Certified Nursing Assistant) transferred R1 from R1's wheelchair to R1's bed with a seated mechanical lift. R1 followed commands for R1's hand placement during the transfer.

On 5/6/19 at 2:00 PM, V3 (Certified Nursing Assistant) stated that on 4/26/19 V3 attempted to transfer R1 from R1's wheelchair to the bathroom. V3 verified that V3 did not request assistance while utilizing the mechanical lift to transfer R1. V3 stated that V3 should have obtained a second staff member to assist during the mechanical lift transfer. V3 stated that as V3 lifted R1 using the mechanical lift, R1 started to slip out of the sling and lower towards the floor. V3 stated that V3 tried to get the wheelchair under R1 but R1 continued to lower to the ground and landed on R1's buttocks. V3 stated that V3 was utilizing an extra large sling and V3 thinks that the sling may have been too large for R1.

On 5/7/19 at 9:30 AM, V5 (Unit Manager) stated that R1 was a two person stand pivot assist before coming to the facility. V5 stated that R1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003446	A. BUILDING: _____ B. WING _____	C 05/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND OF GALESBURG	280 EAST LOSEY STREET GALESBURG, IL 61401

(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
S9999	Continued From page 6	S9999		

was deemed to utilize the sit to stand mechanical lift since R1 was able to sit on the edge of the bed, bear some weight and hold on to the handle bars. V5 verified that V3 should have had a second staff member present when transferring R1 from R1's wheelchair to the bathroom. V5 verified that the mechanical lift's manufacturer guidelines document that if a resident is able to hold on to the handles with one or both handles, then the resident should hold on to the handles. V5 verified that as a result of R1 falling while transferring in the mechanical lift, R1 was sent to the local hospital and found to have a dislocated left hip.

On 5/7/19 at 10:45 AM, V2 (Director of Nursing) stated that on 4/26/19, V3 (CNA) attempted to transfer R1 with a mechanical lift from the wheelchair to the bathroom. V2 verified that V3 tried to implement this transfer alone and should have asked for assistance from a second staff member for the transfer. V2 stated that as R1 went up in the mechanical lift, the sling slid up R1's back, R1's arms went inside the sling and R1 began to slide down. V2 stated that R1 was found with the sling still around R1 with R1's arms tucked inside the sling and R1's feet on the foot rest. V2 verified that R1's arms should have remained outside of the sling while being transferred. V2 stated that when R1 returned to the facility, the facility obtained orders to make R1 a total seated mechanical lift instead of the sit to stand mechanical lift.

(A)