STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005276	A. BUILDING: _____ B. WING _____	C 01/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIXON REHAB & HCC	800 DIVISION STREET DIXON, IL 61021

(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	Final Observations Statement of Licensure Violation: 1 of 1 Violation 300.1210b)5) 300.1210d)6) 300.3240a) 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. Restorative measures shall include, at a minimum, the following procedures: 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. 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	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
	IL6005276	A. BUILDING: _____ B. WING _____	C 01/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIXON REHAB & HCC	800 DIVISION STREET DIXON, IL 61021

(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 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. (A, B) (Section 2-107 of the Act) These Requirements are not met as evidenced by: Based on interview and record review the facility failed to ensure R1 was transferred in a safe manner using a mechanical lift. This failure resulted in R1 sustaining a left hip fracture. This applies to 1 of 3 residents (R1) reviewed for safe transfers in the sample of 6. The findings include: R1's electronic face sheet showed R1 was admitted to the facility on March 3, 2015 with diagnoses to include dementia, difficulty walking, osteoporosis, chronic obstructive pulmonary disease and peripheral vascular disease. R1 was readmitted to the facility on January 22, 2018 with a diagnosis of displaced intertronchanter fracture of the left femur (left hip fracture). R1's Minimum Data Set dated November 28, 2017, showed R1 was totally dependent on staff	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005276	A. BUILDING: _____ B. WING _____	C 01/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIXON REHAB & HCC	800 DIVISION STREET DIXON, IL 61021

(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	S9999		

for transfers. R1's fall care plan dated January 25, 2017 showed R1 required a mechanical lift with the assistance of two persons for transfers and to ensure this was the method used (This intervention was dated November 13, 2012). On January 19, 2018 there was a new intervention recorded to educate CNAs (Certified Nursing Assistant) on proper placement of mechanical lift sling.

The facility's initial report to Illinois Department of Public Health dated January 19, 2018, showed,"Today during a mechanical lift transfer with two CNAs present, R1 slid out of her mechanical lift sling. Staff attempted to intervene and lower her to the floor, but were unsuccessful in doing so in which R1 landed on the floor on her buttock. A skin assessment was performed immediately and range of motion was noted to be within normal limits. R1 did complain of pain to her left hip, physician was notified and orders were given to send R1 to the hospital for x-rays. The hospital called to notify the facility that R1 has an acute comminuted intertronchanter fracture of the left hip..."

The facility's final report to Illinois Department of Public Health dated January 22, 2018, showed the facility determined through interview and investigation the right bottom loop on the mechanical lift sling was not secured and detached from the mechanical lift which resulted in the resident (R1) sliding out of the sling. The staff were unsuccessful in their attempt to intervene and the resident landed on her buttock/left hip. The director of nursing inspected the sling and found the sling in good working condition. The maintenance director inspected the mechanical lifts and found "no deficiency". R1's family chose not to have a surgical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005276	A. BUILDING: _____ B. WING _____	C 01/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIXON REHAB & HCC	800 DIVISION STREET DIXON, IL 61021

(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		

intervention for R1's fracture from this occurrence. R1 will return to the facility on January 22, 2018.

On January 30, 2018 at 8:20 AM, V2 (Director of Nursing) stated on January 19, 2018, V3 and V4 (CNAs) were transferring R1 from her bed to her wheelchair using a mechanical lift. R1 slid out of the sling onto the floor. R1 sustained a "broken hip" and passed away on Friday (January 26, 2018). R1's family choose not to have R1's fractured hip surgically repaired. V2 was asked how R1 slid from the mechanical lift sling. V2 stated V3 did not secure the loop on the mechanical lift sling and the loops came loose and R1 slid out. V2 stated V3 should have ensured all four loops were secured for a safe transfer.

On January 30, 2018 at 8:30 AM, V1(Administrator) stated the incident on January 19, 2018 occurred when the loop (on the sling) came undone (from the mechanical lift). "It was not equipment error it was human error. The sling and mechanical lift were checked and there were no issues. It was human error."

On January 30, 2018 at 9:05 AM, V5(CNA) stated she was working January 19, 2018 on R1's hall. Around lunch time she entered R1's room to help with the transfer and saw R1 on the floor. V3 and V4 said R1 slipped out of the sling. V5 went to get R1's nurse. When V5 came back to the room, R1 had a pillow under her head and a blanket on. R1 was moaning. V5 stated the mechanical lift sling was attached by three of the four loops. One of the leg loops was not attached. V5 stated R1 was sent out to the hospital and was admitted with a fractured hip. V5 stated R1 returned to the facility a few days later. R1 was not the same person,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005276	A. BUILDING: _____ B. WING _____	C 01/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIXON REHAB & HCC	800 DIVISION STREET DIXON, IL 61021

(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		

she had declined. R1 was moaning when she usually would yell out. R1 was not eating or drinking. V5 stated prior to the fall R1 ate in the dining room and would converse with the staff. R1 was not a big eater but with encouragement the staff could get her to eat and drink. After R1 returned from the hospital she was bed ridden with orders not to transfer and reposition her from her back to her right side. R1 was not eating or drinking. R1 passed a few days later. "It was the worst thing I have ever seen."

On January 30, 2018 at 9:20 AM, V6 (CNA) stated prior to R1's fall she was alert but had some memory issues. R1 was a mechanical lift and was total care. "R1 was a sweetheart and had an infectious smile. She had her days but for the most part she was happy. She was able to converse using short sentences. R1 could be combative with cares but never had an issue with being transferred with the mechanical lift. V6 stated R1 was not the same when she returned from the hospital from the fall. R1 was no longer speaking with her, she would randomly scream out. She would look at you, but she would look through you. She would not eat or drink. Before she loved her fruit and vegetables and cranberry juice. After the fall I couldn't get her to eat them or drink the juice. She had a blank stare and before she talked a lot." V6 stated she was surprised to hear that R1 had fallen out of the sling. if the loops are secured they don't fall off."

On January 30, 2018 at 11:05 AM, R5 stated she was R1's roommate for the past six months. R5 was not in the room when the incident occurred on January 19, 2018. R5 stated R1 was different when she came back from the hospital. "She was in bad shape. She stayed in bed all the time. She was moaning and yelling out. The girls couldn't

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005276	A. BUILDING: _____ B. WING _____	C 01/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIXON REHAB & HCC	800 DIVISION STREET DIXON, IL 61021

(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		

get her to eat. A few days later there was a commotion in my room, they told me to go to the activity room. I knew she died. She is in a better place now."

On January 30, 2018 at 1:40 PM, V3 stated she was working the first and second shift on January 19, 2018. V3 was assigned the 200 hall. She finished getting her residents up for lunch and went over to the 100 hall to help them get residents up for lunch. V5 asked her to help transfer R1 into her chair. They walked down towards R1's room. A bathroom call light went off and V5 went to answer the light. V3 proceeded to R1's room. V3 stated she placed the sling and hooked R1 up to the lift. V3 stated she tugged on the sling and thought the loops were secure. V3 went to the door to get V5. V4 was in the hall and said she would help with the transfer. V3 stated she worked the lift and V3 was by R1's wheelchair. V3 maneuvered the lift toward the wheel chair when the strap by R1's right leg came loose and R1 fell. R1 landed on her buttock and left hip. At that time V5 entered the room, V3 asked V5 to get the nurse. V7(Registered Nurse) entered the room and did an assessment and then left to get V2. V7 and V2 looked R1 over. Then we put the sling under her and lifted her up into bed. V3 was asked how she thought R1 fell from the sling. V3 stated she must not have put the loop on all the way and with the weight of R1 the loop slid off and R1 fell. V3 stated there was no fraying or malfunction of the sling.

On January 30, 2018 at 2:00 PM, V4 stated she was working R1's hall on January 19, 2018. She had transferred R1 earlier in the shift with the mechanical lift with no problems. V4 said around 11 :30 AM, she went to help V3 transfer R1 from the bed to her wheelchair. when V4 entered the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005276	A. BUILDING: _____ B. WING _____	C 01/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIXON REHAB & HCC	800 DIVISION STREET DIXON, IL 61021

(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		

room R1 was already hooked up to the lift. V4 went behind R1's wheelchair to guide her and V3 operated the lift. One corner of the sling slid off the lift and R1 fell to the ground and landed on her back and buttock. R1 said it hurt and "Ouch". V4 put a pillow under her head and a blanket on R1 because R1 said it was cold. V2 and V7 came into the room and checked R1 out. We took the sling off the lift and rolled R1 onto the sling and then we (V2, V3, V4, V5 and V7) lifted R1 unto her bed. V4 stated the next time she saw R1 was a week later. R1 was not her normal self. R1 was bedridden, on oxygen which was new for R1.

On January 30, 2018 at 11:30 AM, V7 stated on January 19, 2018, V5 came to the nurses station and reported that the CNAs needed her in R1's room immediately. R1 was on the floor. V5 entered R1's room and saw R1 on the floor, the mechanical lift was in the middle of the room and the sling was hanging on the lift by 3 loops and one loop was not attached to the sling. V7 went over to R1 and asked her how she was doing. R1 said she was cold and had no other complaints. V7 stated she assessed R1 and found no injuries. V7 stepped into the hall and asked V2 to come down to R1's room. V2 and V7 assessed R1, did range of motion and neuro check. R1 had a skin tear to her left elbow. V2 left to get the wound nurse. We (V2, V3, V4, V5 and V7) log rolled R1 unto the sling and manually lifted her unto her bed. V2 stayed with R1 while V7 went to call R1's physician. We called R1's daughter and told her we were sending R1 out to the emergency room. We called the paramedics and they transported her to the emergency room. V7 said she asked R1 if she knew what happened. R1 said"I don't know. I just fell." V7 stated prior to the incident R1 was alert and oriented to person and place. She was total care. R1 was able to talk in short

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005276	A. BUILDING: _____ B. WING _____	C 01/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIXON REHAB & HCC	800 DIVISION STREET DIXON, IL 61021

(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 7	S9999		

sentences. After the incident, R1 was alert. R1 was left in bed due to pain control issues and a fractured hip that was not surgically repaired. R1 was admitted to hospice when she returned from the hospital. R1 was not eating or drinking"much" when she returned. R1's oral medications were discontinued because she was having difficulty swallowing when she returned. V7 was asked how she thought R1 fell. V7 stated there was no malfunction of the sling nor lift. One of the loops on the sling came off the loop because it wasn't all the way on. The loop should not come off if it is put on properly.

R1's hospital history and physical dated January 20, 2018, showed R1 was admitted to the hospital with a left hip fracture following a fall. R1 slid out of a mechanical lift and landed on her left hip. R1 was complaining of left ankle pain at the time and was sent to the emergency room and was found to have a left femoral neck fracture. R1 was seen by the emergency room physician, who after a prolonged discussion with R1's Power of Attorney, has advised against surgery. At this time R1's POA is present and we have discussed conservative management including a referral to hospice care. R1 has no pain at present but does have severe pain with movement. R1 has severe chronic obstructive pulmonary disease and had low oxygen saturations of 88 percent during the night. R1 is on oxygen at 2 liters per minute via nasal cannula. Assessment and plan include R1 has a left hip fracture. R1 is not a surgical candidate, and the recommendation is for hospice referral to which the POA is going to discuss with her siblings. R1 is not able to take much opiods secondary to her COPD. At the present time the patients pain seems to be controlled. In the recent past when R1 was restricted to her room, she got severely

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005276	A. BUILDING: _____ B. WING _____	C 01/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIXON REHAB & HCC	800 DIVISION STREET DIXON, IL 61021

(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 8 depressed and stopped eating secondary to the hip fracture. R1 may experience pain that is not fully controlled especially when moved. The POA will discuss this also with the family. The history and physical was electronically signed by V8 (R1's personal physician). R1's CT scan (Computed Tomography scan) of pelvis without contrast dated January 19, 2018, showed acute comminuted intertrochanteric fracture of the left hip. (A)	S9999		