STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012553	A. BUILDING: _____ B. WING _____	C 09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA TERRA SCHAUMBURG	675 SOUTH ROSELLE ROAD SCHAUMBURG, IL 60193

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S 000	Initial Comments Incident Report Investigation to Incident of August 30, 2022/IL151445-	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 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.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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: 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 interview and record review the facility failed to ensure a resident (R1) was transferred, via a mechanical lift, in a safe manner. This failure resulted in R1 falling out of a mechanical lift on August 30, 2022. R1 was emergently sent to a local hospital where she was subsequently admitted to the intensive care unit (ICU) with diagnoses of a scalp laceration and subarachnoid hemorrhage (brain bleed). This failure had the potential to affect all 13 residents (R1, R2, R7-R17), on the third floor of the facility, that required the use of a mechanical lift for transfers. The findings include: A Facility Incident Report for R1, dated August 30, 2022, showed R1 was being transferred by a	S9999		

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S9999	Continued From page 2	S9999		

mechanical lift when she slipped out of the lift and fell to the ground, striking the left side of her head. R1 sustained a laceration to the left side of her head. R1 was immediately sent to a local hospital for an evaluation.
R1's hospital History and Physical report dated August 30, 2022, showed R1 presented to the hospital due to "a fall from mechanical lift during transfer, laceration noted to left scalp". The report showed R1 was diagnosed with a subarachnoid hemorrhage and required 5 staples to close the laceration to her scalp. R1 was admitted to the ICU.
R1's current care plan showed R1 was severely cognitively impaired related to her diagnoses of dementia and intellectual disabilities. The care plan showed R1 was totally dependent on staff for transfers which included the use of a mechanical lift.

The Operating Manual for the facility's mechanical lift, dated November 2017, showed for resident transfer, the resident was to be placed on a fabric sling and then attached to the mechanical lift by four loops on the sling. The mechanical lift had four hanger rods (metal hooks), where each of the loops of the fabric sling attached to the lift. The manual showed that each hanger rod had a grommet (hanger rod clip/metal clip) attached to the rod to ensure the loops of the fabric sling stayed in place during a resident transfer. The Manual showed, "Inspect the lift and sling to make sure they are undamaged and in good working order" prior to use. The Manual also showed, "Verify hanger rods and grommets (metal clips) are present and in working condition."

On September 21, 2022, at 8:50 AM, V3 CNA stated she was providing cares to R1 on August

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S9999	Continued From page 3 30, 2022, when R1 fell out of the mechanical lift. V3 stated, "The (mechanical) lift on the third floor had been missing a metal clip on one of the hooks (hanger rods) for a while. We had no other lift to use on the third floor, so we had to use it. (V8 CNA) and I went to transfer (R1) from the bed to her wheelchair when the lower left part (hanger rod) of the lift dipped down and the sling came apart from lift. The lower left (hanger) rod was missing the metal clip. (R1) fell out of the lift, falling onto the floor, hitting her head on the lift ...Everyone knew the lift was missing a clip." On September 21, 2022, at 12:45 PM, V3 CNA stated, "I reported verbally to (V7 Third Floor Manager) sometime in August (2022) that the lift was missing a metal clip, but I never put in a work request to have maintenance look at it. I can tell you that I worked on, August 23, 2022. From that date on, the lift had been missing the clip. Even after (R1) fell out of the lift on August 30, 2022, we asked (V2 Director of Nursing/DON) if we should continue to use the lift with the missing clip and she told us we could. We (V3, V8) tried to tell her (V2 DON) that (R1) fell out of the lift because the clip was missing. (V2 DON) told us to stop blaming the fall on the missing clip. We then used the lift to transfer (R7) and (R8)." V3 CNA's August 2022 timecard showed V3 worked August 23, 24, 25, 26, 30, and 31, 2022. On September 21, 2022, at 9:10 AM, V8 CNA she was providing cares to R1 on August 30, 2022, when R1 fell out of the mechanical lift. V8 stated, "One of the clips on the third floor (mechanical) lift had been missing for a while. The clips were used to lock the sling in place on the hooks of the lift. It was the only lift on the third floor, so we had to use it. (R1) fell out of the lift when the sling came away from the lift, down by (R1's) left leg. That was the hook on the lift that was missing the	S9999		

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S9999	Continued From page 4	S9999		

metal clip." V8 CNA stated she notified V2 DON verbally of the missing metal clip "sometime in August" but stated she never filed a work request to have maintenance fix/evaluate the mechanical lift.
On September 21, 2022, at 12:48 PM, V8 CNA stated, "I can also verify I worked August 23, 2022. From that date on, the lift was missing the metal clip. There was no other lift on the floor, so we had to keep using it. After (R1) fell on August 30, I tried to tell (V2 DON) that she fell because the lift was missing a clip. (V2 DON) told me (R1's) fall did not happen because of the missing clip. She told us we could still use the lift to transfer residents. We then transferred (R7) and (R8)." V8 CNA's August 2022 timecard showed V8 worked August 23, 24, 25, 26, 30, and 31, 2022.

On September 21, 2022, at 1:00 PM, V18 Registered Nurse (RN) stated, "I was here on August 30, 2022, when (R1) fell out of the lift. I overheard (V2 DON) tell (V3 and V8 CNAs) that they could continue to use the lift with the missing clip to transfer residents."

On September 21, 2022, at 10:55 AM, V2 DON stated she was unaware that the mechanical lift on the third floor was missing a grommet/metal clip until after R1 fell out of it on August 30, 2022. V2 stated, "I know (R1) fell out of the lift when the sling, by her left leg, came off the hook of the lift." V2 stated, "If the staff didn't feel that lift was safe to use, they shouldn't have used it." V2 DON denied telling V3 CNA and V8 CNA they could continue to use the lift with the missing clip, after R1's fall on August 30, 2022.

On September 21, 2022, at 2:00 PM, V7 Third Floor Manager stated she was unaware that the

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S9999	Continued From page 5	S9999		

mechanical lift on the third floor was missing a grommet/metal clip until after R1 fell out of it on August 30, 2022. V7 stated the mechanical lift was taken out of service on August 30, 2022.

On September 21, 2022, at 12:30 PM, V10 Maintenance Director stated he was unaware that the mechanical lift on the third floor was missing a grommet/metal clip until after R1 fell out of it on August 30, 2022. V10 stated, "When equipment is broken or something is wrong, staff are to put a work order in the computer, so I know it needs to be looked at. I would then take the equipment out of service until I can look at it. If a metal clip is broken off one of the hooks of the lift, the lift should not have been used. The clips serve as a locking mechanism for the lift." V10 denied ever receiving a work order/request to fix the third-floor mechanical lift. V10 stated the mechanical lift on the third floor was taken out of service on August 30, 2022.

On September 21, 2022, at 11:18 AM, V14 (Quality Assurance Manager for the mechanical lift company) stated, "The hanger rod clip, on the mechanical lift, is a double-check mechanism to make sure the loops of the cloth sling stay in place on the hooks of the lift. If the clips are not in place, the loops of the sling could slip off the hooks of the lift, causing a person to fall. If a rod clip is broken or missing, the lift should not be used."

The facility's Mechanical Lift Transfers policy dated July 28, 2022, showed. "1. Follow Manufacturer's guidelines on how to operate machine."
The facility's Maintenance policy dated July 28, 2022, showed, "2. Any staff who is made aware of a malfunctioning equipment or any part of the

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S9999	Continued From page 6 building that is in disrepair will report the issue to the maintenance department." (A)	S9999		