STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008361	A. BUILDING: _____ B. WING _____	C 07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYNSCAPE HEALTH & REHAB	2180 MANCHESTER ROAD WHEATON, IL 60187

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S 000	Initial Comments Facility Reported Incident of 7/5/2022/IL149119	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 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. 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 c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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. These requirements were not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow R1's care plan and facility policy while conducting a transfer using a mechanical lift. This resulted in R1 falling from a mechanical lift and sustaining a subdural hemorrhage and lacerations that required emergency room services and hospital services. This applies to 1 of 3 (R1) reviewed for safety during transfers. The findings include: The EHR (Electronic Health Record) shows that R1, a 93-year-old with diagnoses of Alzheimer's Disease, AHSD (atherosclerotic heart disease), HTN (hypertension), essential tremor, history of falling, hyperlipidemia, major depressive disorder,	S9999		

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S9999	Continued From page 2 syncope and collapse, atrial fibrillation, dementia, glaucoma and mood disorder. The MDS (Minimum Data Set) dated 4/11/2022 shows that R1 was assessed for total assist of all aspects of ADLs (Activities of Daily Living). The MDS also shows that R1 scored 4/3 for transfers (total assistance with 2-3 person assist). The current care plan dated 4/14/2022 shows that R1 uses the total transfer lift device for transfers from bed to wheelchair and vice versa. The care plan shows that 2-person assist is required for transferring R1 with the use of the transfer lift device. The fall risk assessment dated 7/7/2022 shows that R1 scored 75, a high risk for fall. The fall assessment legend shows that a score of 0-24 is not a risk; 25-50 is low risk; and 51 and above is a high risk for fall. The incident report dated 7/5/2022 at 4:30 P.M., shows that R1 had a fall during transfer from bed to wheelchair using the total lift mechanical device. The report shows that V3 (CNA/Certified Nurse Assistant) was the only staff who assisted R1 during this transfer that had caused R1's fall. The report shows that the total lift transfer device tilted while R1 was hoisted up for transfer by V3. The report also shows that R1 landed on the floor, on her right side and a moderate amount of blood was noted under right side of her head. The transfer lift device also tilted and ended on the floor next to R1's feet. R1 was sent via 911 at 4:38 P.M. on 7/5/2022. The clinical notes entered 7/6/2022 at 12:41 A.M. show that a nurse was alerted by CNA that R1 had fallen on the floor during transfer and that the	S9999		

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S9999	Continued From page 3	S9999		

total lift mechanical transfer device had tilted forward. The notes also show that when the nurse checked R1, R1 was found lying on the floor with the sling of transfer device underneath R1 and the transfer lift device was by R1's feet. The recliner chair was also next to R1. R1 was moaning, /groaning and mumbling. Blood was noted coming from R1's left nostril, and a small cut on right eyebrow. The notes show that R1 was sent out via 911 and was admitted with subdural hemorrhage.

On 7/19/2022, staff who had knowledge regarding R1's care and fall incidents were interviewed:

- At 10:30 A.M., V1 (Administrator) stated V3 should have not transferred R1 alone by herself. V1 said R1 was transferred by V3 using the total lift transfer device on 7/5/2022 at around 4:30 P.M. V1 said during the transfer, the transfer lift device had tilted and R1 ended on the floor with the transfer lift device. V1 said when she interviewed V3 regarding the fall incident, V3 admitted that she was by herself and no other staff assistance. V1 said it is always 2-person assistance that is required when transferring a resident using the total lift transfer device. V1 said V3 did not follow proper transfer policy regarding using the total transfer lift device.

- At 11:00 A.M., V2 (Interim DON/Director of Nursing) said R1 uses the total lift mechanical transfer device for transfers from bed to wheelchair and vice versa. V2 said that 2-person assistance is always required when R1 is being transferred. V2 said she immediately went to R1's room when R1 fell while being transferred from bed to wheelchair by V3 on 7/5/2022 around 4:30 P.M. V2 said she found R1 lying on the floor on

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S9999	Continued From page 4	S9999		

her right side. R1 was bleeding on her right side of head and face. R1 was also lying on the floor with the sling of the transfer device still attached on R1's back. V2 said that the transfer lift device was on the floor on tilted position next to R1.

- At 11:56 A.M., V4 (LPN/License Practical Nurse, on duty when R1 fell on 7/5/2022) said that V3 was from staffing agency. V4 said she informed V3 that R1 requires a mechanical total transfer lift device when transfer from bed to wheelchair and vice versa. V4 said she also informed V3 to ask for help when R1 is to be transferred since requirement of 2 person is needed. V4 said she immediately checked R1 when V3 informed her that R1 fell to the floor when she transferred R1, and the transfer device had tilted. V4 said R1 was noted with blood coming from the right side of face and head. V4 said R1 was sent out via 911 and was admitted with subdural hemorrhage.

- At 12:10 P.M., V6(CNA) said R1 fell on 7/5/2022 around 4:30 P.M. when V3 transferred R1 from bed to wheelchair. V6 said the transfer lift device tilted and R1 went down with the transfer device. V6 said V3 did not ask for help during R1's transfer.

- At 5:00 P.M., V5 (CNA) said V3 did not ask for help when V3 transferred R1 by herself using the total lift transfer device. V5 said that 2-person assist is required using the total lift deice when transferring R1.

- At 12:10 P.M., V3 (CNA) said on 7/5/2022 at around 4:30 P.M., V3 looked in the hallway and saw no other staff, so she decided to transfer R1 by herself. V3 said during the transfer, the total lift device tilted to the right side, and R1 went down with the device. V3 said she immediately

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S9999	Continued From page 5 informed V4 regarding R1's fall. The hospital record dated 7/5/2022 at 5:30 P.M. shows R1 had sustained an acute subdural hematoma and acute subdural right temporal subarachnoid hemorrhage, a punctuate wound laceration to the right side of face, small laceration to right side of cheek, and right eyebrow, ecchymosis on the right orbital area, right hand, and right knee due to R1's fall from the total lift device. R1 was admitted to the hospital and was transferred back to the facility on 7/7/2022. On 7/19/2022 at 11:30 A.M., R1 was observed being transferred with a total transfer lift device being assisted by V6 and V7 (CNAs) with V2's supervision. R1 was non-responsive both verbal and tactile stimuli. R1 was observed with dried scabs on her right forehead and right eyebrow. V2 said, "those were the lacerations sustained from the fall that were stitched, and the stitches were removed already." The facility's policy with revision date of December 2013 regarding "Safe Lifting and Movement of Residents" shows "In order to protect the safety and well-being of staff and residents, and to promote quality care, the facility uses appropriate techniques and devices lift to lift and move residents. ...7 ...All lifts will be used with 2 persons assist." (A)	S9999		