STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003024	A. BUILDING: _____ B. WING _____	C 03/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRHAVEN CHRISTIAN RET CENTER	3470 NORTH ALPINE ROAD ROCKFORD, IL 61114

(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 Original complaint investigation survey 2311906/ IL#157221 Incident Report Investigation to Incident of 2/12/23/ IL#157177	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 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 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 resident to meet the total nursing and personal care needs of the resident. 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. These Regulatiosn were not as evidenced by: Based on observation, interview and record review the facility failed to transfer a resident in a safe manner using a mechanical lift for 1 of 3 residents (R1) reviewed for safety during mechanical lift transfers in the sample of 5. This failure resulted in R1 sustaining a fractured hip. The findings include: The resident face sheet for R1 shows she was admitted to the facility on 12/17/18 and re-admitted on 2/16/23 with multiple diagnoses including disorientation, nontraumatic subdural hemorrhage, and fractured hip. The 12/9/22 facility annual assessment documents R1 to have severe cognitive impairment. The same assessment shows she was dependent on two staff for transfers between surfaces including to or from bed and wheelchair. R1's 12/28/18 care plan for falls shows she is at risk for falls due to poor safety awareness and a	S9999		

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S9999	Continued From page 2	S9999		

history of falls. She uses a wheelchair for mobility and mechanical lift for transfers with two staff assist. The care plan was updated with a fall on 2/12/23 and notes she fell during a mechanical lift transfer and fractured her left hip.

The 2/12/23 nursing progress notes for R1 document the nurse was called to R1's room and observed her lying on her right side with her legs lying across the leg of the mechanical lift, and her head resting on the other leg of the lift. Blood was noted on the right side of her head and the left hip was observed to be hyper-flexed. R1 stated the left hip hurt when touched. The note documents R1 was sent out to the emergency room and diagnosed with a left hip fracture. The notes show she returned to the facility on 2/16/23.

The 2/12/23 facility incident report shows R1 was being transferred via mechanical lift from the wheelchair to the bed when she began to lean to the right side and fell from the lift sling unto the floor.

On 3/7/23 at 10:10 AM, V6 CNA (Certified Nursing Assistant) said she was walking in the hallway when she heard a big boom. She opened the door to R1's room and found V3 CNA in the room, and R1 was on the floor. She said V3 was the only person in the room, and was saying "she fell, I always ask for help". V6 said V3 appeared to be shock and really scared. V6 said V3 never called for assistance to transfer R1, the staff have radios and can easily call for help with transfers. V6 said she remembers R1 way lying across the legs of the mechanical lift and had blood near her head. The sling for the mechanical lift was still hanging from the bar above R1, and the leg part of the sling was criss-crossed. V6 said she believes R1 fell out

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S9999	Continued From page 3	S9999		

the side of the sling. V6 said it is the policy of the facility to use 2 people for mechanical lift transfers, for safety. V6 said V2 DON (Director of Nursing) had an in-service on resident safety and transfers on 1/31/23. V6 said there was no reason for V3 to transfer R1 by herself, she should have asked for help.

On 3/7/23, calls to V3 were not returned. Her written statement for the 2/12/23 facility incident report documents she hooked the sling to the mechanical lift and started transferring R1 from the wheelchair to the bed. R1 began to lean to the right side and fell from the lift sling. She tried to catch her but could not.

On 3/7/23 at 10:00 AM, V5 CNA said R1 was a mechanical lift transfer, and there are always 2 staff members required for the transfer. She said one staff drives the lift and controls the up and down transfer. She said the second staff keeps their hands on the resident and keeps them safe. She said if a second staff is present, they would be able to catch the resident leaning and prevent them from falling. It is dangerous to do it (transfer) alone.

On 3/7/23 at 12:15 PM, V2 said she had an in-service on 1/31/23 regarding safe transfers, and the facility policy to always use 2 staff when using the mechanical lift. She said V3 did not follow the policy, and as a result R1 fell about 4 feet from the sling and sustained a fractured hip when she landed on the floor. V2 said the fracture was complicated and non-repairable with surgery. V2 said when she interviewed V3, she admitted to transferring R1 alone with the mechanical lift. When R1 returned to the facility, she was on bed rest and pain management. She was placed on comfort measures and did not return to the quality

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S9999	Continued From page 4 of life she had prior to the fall. The facility's 1/8/08 policy and procedure for limited lift program documents the purpose of the policy is to determine safe handling and transferring of residents. The procedure: 6. Two (2) staff persons must be present for all mechanical aided transfers. (A)	S9999		