STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000426	A. BUILDING: _____ B. WING _____	C 12/21/2023

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APOSTOLIC CHRISTIAN SKYLINES	7023 NORTH EAST SKYLINE DRIVE PEORIA, IL 61614

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S 000	Initial Comments Facility Reported Incident of November 27, 2023 IL167408 Complaint Investigation 23210484/IL167874	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 d)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 resident to meet the total nursing and personal	S9999	**Attachment A** Statement of Licensure Violations	

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care needs of the resident.
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 are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to provide safe transfer during a bath for one (R1) of three residents reviewed for transfers in a sample of three. This failure resulted in R1 being hospitalized and suffering from fractures to his right proximal humerus and C2 (cervical vertebrae).

Findings include:

The facility's Fall Occurrence Policy, dated 2/2/2022, documents, "Policy: (Named facility) wants to create an environment that is free from accident hazards as much as possible for residents, provide supervision when needed, and assist with detecting and preventing hazardous situations."

The facility's undated "(Named) Transfers and Stretcher Safe Operation & Maintenance Manual" documents, "System Preparation (Before Transferring or Lifting): 9. All residents must always be securely safety belted at the waist when using any of the (Named) Lift Systems. Ensure that the safety belt is routed through the loose buckle end as shown in the picture to the

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left. Pay close attention to the placement of the serrations of the buckle. If routed the opposite way, the safety belt will slip. Tighten safety belt by pulling on the loosed end of the safety belt. Warning: Failure to secure the resident properly with the safety belt could result in injury to the resident or operator." "Warning: Failure to ensure hands, arms and legs are clear of any objects when transporting or lifting could result in injury to the resident or operator. Push the emergency stop button, on the Control unit at any time during raising and lowering of resident." "17. Upon completion ensure the residents hands, arms, and legs are clear before raising the lift. Push the up button to raise the resident slightly if needed, and then drain the water from the spa." "21. Before you move the Transfer away from the spa, make sure the lower extremities have been toweled dry so the bath floor stays dry. Ensure the Transfer is raised high enough to clear the spa seat. You may now unlock the casters and move the Transfer out of the spa and away, ensuring the resident is still safety belted correctly and the resident's hands, arms, and legs are all clear."

R1's Minimum Data Set/MDS assessment, dated 9/12/23, documents R1 has Vascular Dementia, requires limited assist of one assist for transfers, requires physical help of one assist for bathing, is not steady and only able to stabilize with staff assistance during transitions and walking. This same assessment documents in Section C Cognitive Patterns: "B. Inattention - Did the resident have difficulty focusing attention, for example being easily distractible, or having difficulty keeping track of what was being said? 2 = Behavior present, fluctuates (comes and goes, changes in severity). C. Disorganized thinking - Was the resident's thinking disorganized or

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incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, our unpredictable switching from subject to subject)? 2 = Behavior present, fluctuates (comes and goes, changes in severity)."

R1's current Care plan includes the following: R1 has a diagnosis of dementia and is exhibiting some cognitive loss; approaches include to "Provide verbal cues and reminders as required related to orientation and time." R1 is at risk for falls - approaches includes to "Provide assistance with all mobility/ADL (Activities of Daily Living) care needs."

R1's Progress note, dated 10/16/23 by V9, Social Service Director/SSD, documents "(R1) requires frequent reminders due to decreased retention."

R1's Progress note, dated 11/27/23 by V4, Registered Nurse/RN, documents, "This nurse was called in to Spa room by (V2, Certified Nursing Assistant/CNA) stating resident is on floor and slipped out of tub chair. When this nurse went in saw resident face down in blood. Called another nurse to help. With help of couple CNA's and nurses, turned resident on to his back. He was alert and oriented, was able to respond stating help me. After turning resident on to his back we noticed lacerations on his forehead between his eyebrows, and on his nose. Looks like when he slid out of tub chair, he hit his forehead on the edge of the tub. cleansed the area, applied pressure dressing. Called 911. (Local ambulance service) stated not to lift him from the floor. Left him on the floor covered him up and was monitoring him until (local ambulance service) arrived. Resident was alert and communicating with staff. EMT (Emergency Medical Technicians) here. Resident was able to

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S9999	Continued From page 4 answer EMT staff appropriately. EMT staff stated he will need stitches and transported him to (named local hospital). Called and notified resident (Power of Attorney/POA/family member) regarding resident fall and sending him to ER (Emergency Room)." R1's Fall Event Report Work History, dated 11/27/23, and signed by V2, Director of Nursing/DON, documents description of fall: "When bath was complete (V3, CNA) started moving the chair out of the tub while resident was sitting in secured chair to continue cares. Resident was irritated by seatbelt and was verbally aggressive to CNA to take the seat belt off and then he pulled seat belt undone. Resident simultaneously reached forward and tried to grab onto the far side of the tub and while doing this he slipped forward out of the tub chair, hitting his forehead on the edge of the tub and landing on the right side." R1's CT (Computed Tomography) Cervical Spine Without Contrast report, dated 11/27/23, documents, "Impression: Minimally displaced type II fracture of the odontoid process," (part of the C2 vertebrae). R1's X-ray Shoulder Complete Right report, dated 11/27/23, documents "Impression: Acute displaced proximal humeral fracture." On 12/20/23, at 11:06am, V3, CNA, stated, "I was pulling the spa chair out of the tub and at that moment (R1) started to lean forward so I reminded him to lean back and that we were getting out of the spa tub. He did lean back so I continued to pull the chair from behind. I didn't realize that he had removed the seat belt from around his waist and he slipped out of the chair	S9999		

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as he reached for the tub. He fell forward and his head hit the bottom of the tub." V3 also stated, "(R1's) cognition varies day by day. He has periods of forgetfulness. That day he seemed his usual, nothing that would alarm me. He is a one assist gait belt wheeled walker for transfers and has been for awhile. I could have double checked everything that's what I learned from the situation. Make sure I didn't forget anything. I doubt I forgot to put it (seat belt) on."

On 12/20/23, at 12:19pm, V4, RN, stated that while V4 was passing medications ,V3 called out to V4 and said (R1) was on the floor. "I saw the blood on his face. I had her stay there and had the other nurse come." V4 also stated "(R1) is forgetful. You constantly have to remind him. When I transfer him from wheelchair to recliner he has to be constantly reminded to take more steps and that he is not there yet. (R1) is often in a rush to sit down or if he wants to do something like stand up. He has put his (lift) chair all the way up then forgets what he was going to do and fell asleep with it up. We have to constantly watch him." V4 continued to state, "He was holding onto the tub and if CNA is not watching his hands and the floor and chair are wet I think he slid out of the chair. It is easy to slide off the chair. There is a belt there, but I think it can come off. It is not a buckled type of belt, but a safety belt. Force can cause it to open up the belt like if forcefully falling forward. I believe the belt was on - (V3 CNA) said she put it on. They are regular CNAs that work with (R1). I think that when he was falling forward the belt opened up. Not when he was holding onto the tub. I don't think it is a belt that is able to hold them in the chair if they are falling out of the chair like sliding out while everything is wet. (R1) likes the spa and is ready for the bath. If he is agitated or restless, the CNAs don't give him

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one. Or if he doesn't want one. But on Mondays he likes it and is ready. He doesn't ever get agitated while in the spa. He is not aware of safety...(V3) should have made sure his hands were on his lap so he was not holding onto the tub. Or could ask for a second person if agitated, but (R1) wasn't."

On 12/20/23, at 1:52pm, V5, CNA, stated V5 has given R1 a spa bath before, and R1 did fine. V5 stated, "He didn't fidget, lean, or get agitated."

On 12/21/23, at 2:10pm, V8, Staff Development, confirmed V8 trains staff upon hire how to use the spa tub and chair. V8 explained after staff undress the resident for the spa bath, they are to put the chair's attached belt around them, then they put the resident in the tub, guiding them giving verbal cues for arms and hands to remain inside the tub chair and in their lap. V8 stated, "Then put them into the tub the way they are maneuvered, watch where their legs and feet are. Once completely in the tub, shut the door and lower them down onto the tub seat. Give their bath. Throughout this whole thing I am big on engagement, verbal cues, giving directions be sure they hear, physical, and verbal prompts as needed from start to end. After washed and rinsed, raise the spa chair up while letting water drain. Once water is out, can open the door. When coming out watch their legs and feet while guiding them out. Verbal cues for arms in throughout the exiting of the tub. Spa tub chair has grips in the back to pull back and guide. You can still see what they are doing while guiding them out. You can also stand where you can be on their side. It's easy to stand on the side of them. They should keep their eyes on their hands, arms, legs and feet at all times when entering and exiting the tub." V8 agreed that

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safety is a big concern during the spa bath. V8 also stated, "If impulsive or forgetful, the CNAs should remind and give the cues. If behaviors they give reassurance and get them through it. If not safe they know not to do it."

On 12/21/23, at 2:39pm, V8 and V3 were in the Spa room. V3 reenacted the incident, and demonstrated she was standing behind the back of the spa chair when bringing R1 out of the tub when R1 fell. V3 stated she was watching his legs and feet while coming out. V3 denied being able to see what (R1) was doing with his hands. V3 stated, "I told him to just relax and we are getting out of the bath. I don't actually say to keep arms in or keep in their lap."

On 12/21/23, at 1:38pm, V2, Director Of Nursing/DON, stated the following: "(R1) had the belt on in the tub and somewhere in between as (V3, CNA) was behind (R1) coming out (R1) had gotten the belt off. (V3) asked if (R1) was ready to come out he said yes. It was when (R1) was getting out that whatever his trigger was he decided to reach for the other side of the tub. By the time (V3) realized what was happening, (R1) was too far away to grab it, was leaning over, fell, and hit his head on the bottom lip of the tub. That's when (V3) realized (R1) didn't have the belt. (V3) didn't see (R1) mess with the belt, but that doesn't mean he didn't. Not sure if maybe the pressure caused it to come off. The rep (from manufacturer) had said if anyone wanted to get out of it they could. (V3) thinks he took it off, but no time to react. If the straps were undone, they would fall in the lap and you wouldn't see it from behind the chair. (V3) would have had to peer around the resident to see the strap's placement and where his hands were. (V3) needs occasional reminders. (V3) said during the bath

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S9999	Continued From page 8 his mood was fine and (R1) wasn't agitated and was calm when he said he was ready to get out. Not sure if his demeanor changed, but something triggered and he wanted out of the chair." (A)	S9999		