STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000400	A. BUILDING: _____ B. WING _____	C 08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APOSTOLIC CHRISTIAN RESTMOR	1500 PARKSIDE AVENUE MORTON, IL 61550

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S 000	Initial Comments Complaint Investigation 2426722/IL177089	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a) 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 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a	S9999		

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comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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.

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.

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S9999	Continued From page 2 These Requirements were not met evidenced by: Based on observation, interview, and record review the facility failed to provide safe transfer for one (R1) of three residents reviewed for transfers in a sample of three. This failure resulted in R1 being sent out to the hospital and suffering from bruising, left elbow hematoma and a head laceration. Findings include: The facility's Fall Prevention policy, dated April 2024, documents "Purpose: To provide as safe an environment as possible by taking measures to prevent falls to the extent possible." The facility's Lift Policy, dated January 2022, documents "I. Purpose - To prevent injury to residents and staff during transfers and to reduce physical strain on staff...J. The Instruction manual for the lift shall be available at each care base for reference. The procedure for transfer with the lift outlined in the manual shall be followed." The facility's Instruction Manual for the (mechanical lift), undated, documents the following: "Intended Use: 'Mechanical lift' shall always be handled by a trained caregiver and in accordance with the instructions outlined in these Operating and Product Care Instructions" and "To lift from a chair: Place the sling around the patient so that the base of his/her spine is covered, and the head support area is behind the head...Raise the patient by operating the handset control, move the lifter away from the chair then carefully lift the positioning handle until the patient is reclined in the sling - the head support will now come into use."	S9999		

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R1's current Face sheet documents R1 has diagnosis including but not limited to Vascular Dementia, unspecified severity, with agitation and Anxiety Disorder.

R1's Minimum Data Set/MDS assessment, dated 4/30/24, documents R1 is severely cognitively impaired, dependent on staff for all cares including transfers, and has no behaviors.

R1's current Care plan documents R1 is at risk for falls related to her impaired cognition and aphasia as evidenced by R1's diagnosis of Vascular Dementia. R1's Care plan documents ""FALL ON (7/22/2024): Fall from lift. CAUSE: Poor core strength; Equipment placement. INTERVENTION: Stays of the sling will be positioned at mid back; Staff Inservice regarding (mechanical lifts) and sling placement." R1's Care plan also states R1 "requires staff assistance with all of her ADL's (Activities of Daily Living)" and "Resident is full (mechanical lift) and (from) transfers to bed to complete toileting functions."

R1's Progress Note, dated 7/22/24 and signed by V3 Assistant Director of Nursing, documents "Called to resident's room at 12:30 for fall. Resident lying supine on floor, moderate amount of blood from posterior head." This note also documents R1 was transferred by ambulance to the local hospital at 1:37pm.

R1's Event Report, dated 7/22/24, created by V2 Director of Nursing/DON documents the following: The occurrence was on 7/22/24, at 12:30pm. Resident unable to state what she was doing when the fall occurred due to impaired cognition and being nonverbal. Locomotion was with staff assist. Staff witness is (V7 Certified Nursing Assistant/CNA). This occurred in resident

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room during staff transfer, resulting in left elbow hematoma, posterior head laceration, and transfer to hospital ER (Emergency Room). This same Event Report also documents "Location/Condition/Statement/Event Scene: Called to residents' room at 12:30pm. Resident lying supine of floor. Staff report she was being transferred from (reclining) chair to bed via (mechanical lift) after lunch. When lifted from the chair, the resident extended her upper body and fell backwards out of the sling. Staff report the stays of the sling were positioned lower, and when she moved back, it seemed to aid in her falling out easier. Hit posterior head on the leg of the lift;" "Primary Cause: Sling placement;" "New/Additional Fall Prevention Strategies Implemented: Other (be specific) - Staff in-service regarding proper sling placement;" and "Description: Fall (7/22/24): Fell from (mechanical lift), sling placed too low on back. When she extended back, it aided in her falling backwards from sling. Cause: Poor core strength. Equipment issue. Intervention: Stays of the sling will be positioned at mid back."

R1's Event Report, dated 7/22/24, documents R1 has a left elbow hematoma and posterior head laceration.
R1's Nurse Progress note, dated 7/22/24, documents "Resident lying on floor, moderate amount of blood from posterior head."
R1's Nurse Progress note, dated 7/23/24, documents bruising noted to R1's left arm and left inner leg.

On 8/27/24, at 12:34pm, V7 Certified Nursing Assistant/CNA stated "The (mechanical lift) sling slipped (R1) backwards while transferring (R1) from the (reclining) wheelchair to bed. I believe the sling was positioned under her incorrectly.

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The sling was already under (R1)." V7 also stated "Usually it (the sling) stays in position when in the wheelchair, but this time it was not. It was not far up enough behind her head and upper back. I determined that as I started lifting her up, then I realized. I started to bring her back down to put her in the chair and that's when it flipped her out." V7 stated that V7 should have made sure the sling was 100% positioned correctly.

On 8/27/24, at 1:45pm, R1 sat quietly in a reclining wheelchair in her room with a mechanical lift sling underneath her. At this time, V9 and V10 CNAs hooked the sling to the mechanical lift, lifted R1 up, and transferred R1 to bed. During this time, R1, nonverbal and sitting still, appeared slightly anxious with eyes wide open; R1 was gripping V10's hand tightly.

On 8/27/24, at 2:21pm, V2 Director of Nursing/DON stated the following "The findings were that the lift sling was not positioned appropriately under (R1) at the time and her jerking movement caused her to fall out the back. Typically, the top of the sling is above the head, and I think it was positioned down too far. The stays are elongated plastic pieces that allows stability and for the sling to be positioned appropriately. Not sure if maybe (R1) had slid down on the sling while it was under her for a few hours while in the (reclining wheelchair) and the CNA (V7) maybe didn't notice that." V2 also stated "(V7) should have ultimately checked placement (of the sling) under (R1) at the time to make sure it was positioned appropriately. We educated (V7) afterwards."

On 8/27/24, at 2:40pm, V3 Assistant Director of Nursing/ADON stated the following: "I got called to (R1's) room and (R1) had fallen out of the lift. I

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S9999	Continued From page 6 did most of the investigation. (V7 CNA) said that when (V7) was getting (R1) out of the (reclining) chair with the (mechanical lift), (V7) had (R1) lifted up when (R1) kind of jerked and slipped backwards out of the sling. When I got there the sling was still hooked up to the lift itself." V3 also stated "I think the stays were positioned down too far by the top of her buttocks and usually the bottom of them should be at mid back. When she jerked and moved backwards, they kind of aided (R1) in pushing herself back." V3 stated that the sling was already under (R1) and that "When hooking up to the lift we want them to pull up the back part of the sling, so the stays are positioned correctly at the back. (V7) should have done this before hooking it (R1's sling) up to the lift." (B)	S9999		