STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145062	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arc at Streator	1525 East Main Street Streator, IL 61364

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review, the facility failed to safely transfer a resident from the bed to the wheelchair using a mechanical lift. This failure resulted in R1 falling out of the mechanical lift sling, landing on his head and left shoulder while his right leg was stuck in the sling still attached to the lift. R1 sustained a right distal femur fracture and multiple spinal compression fractures on 2/22/26. This applies to 1 of 3 residents (R1) reviewed for safety during mechanical lift transfers in the sample of 8. This past non-compliance occurred from 2/22/26 to 3/11/26. The findings include: R1's Incident Report dated 2/22/26 states, Alert resident, with some confusion per baseline was transferring with 2 person assist and the full mechanical lift. Through reenactment and investigation, root cause analysis for fall was determined to be, resident was noted to be fidgeting with sling prior to lifting him in full mechanical lift causing sling to unhook during transfer . On 3/20/26 at 10:40AM V5 (Registered Nurse/RN) stated, The family wanted him up and the other CNA (Certified Nursing Assistant) was on lunch, so (V4 CNA) asked me to help her. We hooked (R1) up to the (mechanical lift) and lifted him up and I was pulling him back and (V4) was kind of on the side of him near his feet. The left upper hook came unhooked, and he went to the floor really fast. (V4) ran and tried to hold his head but his left shoulder and his head hit the floor, and his right leg was still in the sling. We lowered the sling to the floor and got him out of it. He did not yell or call out. He was very startled, we all were. He complained of left shoulder pain and right knee pain. I called for help, and the other nurse went into the room, and I came out here and called 911. The family had been in the hall, and they went in right away to see him. They were not upset. Me and (V4) were frantic. We kept saying we didn't do it on purpose. I called the wife, she is the POA (Power of Attorney). The paramedics were here in a few minutes. There was no blood. He was on the floor, and he was like telling a story. They took him to (local) ER. I saw (V4) hook up the sling, so I don't know what happened. On 3/20/26 at 1:00PM R1 was sitting up in his bed in his room. R1 was alert and friendly with slow, clear speech. R1 was asked if he was having any pain. R1 stated, I have some pain in the back of my head from where they dropped me out of the foyer(mechanical lift) onto the concrete floor. I ate all my fish, I like fish, but I am not really a big eater. Surveyor asked R1 about his right leg (from his recent fracture). R1 stated, I have had trouble with my right leg since my stroke, and I had an amputation of my toes. Right now, it is just kind of numb. Not really painful. I am not crazy about the foyer after that fall, but I got up this morning for breakfast. My head has gotten better, and it is not hurting like it was. On 3/20/26 at 2:10PM V4 (CNA) stated, His daughter asked me to get (R1) out of bed, and my partner was on lunch, so I asked (V5) to help me. We hooked the sling to the machine, and I looked at the loops to make sure they were on the hooks. I then leaned over the bed to get the catheter bag so it wouldn't get caught. We raised him up and (V5) pulled the (Mechanical lift) away from the bed. The (mechanical lift) got hooked on a cord under the bed and it kind of jerked a little bit and the left upper loop came undone, and I don't know what happened, but (R1) went down on the floor on his head. I was between his feet and his bottom ready to guide him to the chair, so when he started to fall, I jolted towards the top of the bed like I was trying to catch him, but it all happened so fast. His head went down first, and his right leg was stuck in the sling. We yelled, but not him. He was not crying out in pain or anything. I (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Actual harm Residents Affected - Few	gave him a pillow, and he was talking to me and trying to have a conversation with me. He always had a tendency to grab onto the sling or the cross bar, and I remember telling him to put his arms across his chest. His daughter came in and said, 'I saw you hook him up, I know it was an accident'. We were trying to figure out what to do, (V5) called 911 and the other nurses came down and assessed him too. This has never happened before that I am aware of. The (mechanical lift) and the sling and everything was fully intact after- we couldn't figure out what happened. I have worked with him since he came back from the hospital, and he knew me right away when I came into the room. He knew I was the one that sat on the floor with him after the fall. He seems the same now. No change in him other than his leg injury. R1's Face Sheet shows that R1 has diagnoses including Hemiplegia and Hemiparesis affecting the left side, Epilepsy and Anxiety. R1's Progress Notes dated 2/22/26 state, Family requested staff to transfer resident to wheelchair for visit. Nurse and CNA secured resident into (mechanical lift) sling ensuring that all loops were attached correctly. Resident was being transferred from bed to chair when hook came unlatched and resident fell out of sling onto left side. Immediate care was provided to resident. C spine maintained. Resident speaking and talking with staff. Would move head side to side to look at staff even when requesting resident to lay still. ROM (Range of Motion) limited to lower extremities per baseline. AxO (alert, orientated) x 3 per baseline. C/o (complained of) pain to right knee and left shoulder and back. Resident has pain to legs at baseline. Bump to left lateral side of head. POA was called and notified. 911 called resident sent to (local) E.R (emergency room) for evaluation. R1's Care Plan dated 2/23/26 (day after incident) states, I have a behavior of grabbing at the sling due to being anxious while being transferred by the (mechanical lift). Interventions include: Have resident hold an object to occupy his hands from grabbing the sling. R1's Hospital Documentation dated 3/4/26 states, Summary of History and Hospital Course: Patient with a history of chronic kidney disease, hypertension, epilepsy, metabolic encephalopathy and prior stroke with left sided weakness, who was admitted following a fall from a (mechanical lift) resulting in a right distal femur fracture and multiple spinal compression fractures. On admission, imaging revealed a displaced right distal femur fracture, chronic right intertrochanteric and left femoral neck fractures, and acute/subacute compression fractures at T12, L1, L2 and L4 with severe osteopenia noted throughout the spine. Orthopedic evaluation determined the right distal femur fracture required surgical intervention, while the chronic hip fractures were managed nonoperatively. He underwent open reduction and internal fixation of the right distal femur using a minimally invasive plate osteosynthesis technique on 2/24/26 with an estimated blood loss of 100 ml and no intraoperative complications. Neurosurgery recommended a TLSO brace for spinal compression fractures when out of bed, with no acute neurosurgical intervention indicated given his baseline bedbound status and chronic deficits . Prior to the survey date of 3/20/26, the facility had taken the following action to correct the noncompliance:Mechanical Lift Audit completed by Maintenance on 2/22/26 and 2/23/26.Sling Audit completed by Housekeeping and Laundry Supervisor on 2/23/26. Any sling with frayed loops or seams was removed from use- total of 3 slings. All residents requiring a mechanical lift were reassessed by licensed nursing staff to ensure safety and proper care plans completed on 2/23/26.100% of staff (in the building) who provide direct care were educated on proper use of mechanical lifts on 2/22/26.Training provided to the staff involved on proper use of mechanical lift with return demonstration on 2/23/26.Any nursing staff that are not available in person have been contacted via phone. If not reachable, will be educated prior to taking shift by DON (Director of Nursing) or designee. Additional Training was provided to all nursing/CNA staff on 3/10/26 and 3/11/26 from an outside agency in the areas of resident transfer status assessment, equipment inspections, gait belt proper transfers, sit to stand proper transfers, total (mechanical) lift proper transfers, proper body ergonomics during transfers, repositions/turning, return demonstration competencies.