

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145436	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/27/2024
NAME OF PROVIDER OR SUPPLIER Apostolic Christian Restmor		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 Parkside Avenue Morton, IL 61550	

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)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>33973</p> <p>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.</p> <p>Findings include:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>R1's current Face sheet documents R1 has diagnosis including but not limited to Vascular Dementia, unspecified severity, with agitation and Anxiety Disorder.</p> <p>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.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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.</p> <p>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 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.</p> <p>R1's Event Report, dated 7/22/24, documents R1 has a left elbow hematoma and posterior head laceration.</p> <p>R1's Nurse Progress note, dated 7/22/24, documents Resident lying on floor, moderate amount of blood from posterior head.</p> <p>R1's Nurse Progress note, dated 7/23/24, documents bruising noted to R1's left arm and left inner leg.</p> <p>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. 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.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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.</p> <p>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 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.</p>		