STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145514	A. Building B. Wing	12/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Effingham Healthcare & Senior Living	1610 North Lakewood Drive Effingham, IL 62401

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. (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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a safe mechanical lift transfer for 1 (R1) of 3 residents reviewed for accidents in the sample of 5. This failure resulted in R1 acquiring a laceration to her head on the top left side resulting in 2 sutures being placed.This past noncompliance occurred between 11/26/25 and 12/1/25. Findings include:R1's admission Record documented an admission date of 11/10/2025 and diagnoses including chronic systolic heart failure, type 2 diabetes mellitus without complications, morbid (severe) obesity due to excess calories, and adult failure to thrive. R1's Minimum Data Set (MDS) dated [DATE], documented under section C- (cognitive patterns) a BIMS (Brief Interview for Mental Status) of 15, indicating R1 was cognitively intact. This same document under section GG- Mobility documented that R1 is dependent, which means helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort for a chair/bed-to chair transfer. R1's Care Plan documented a focus area of R1 having limited physical mobility related to weakness, morbid obesity, osteoarthritis, restless leg syndrome, hypertension, spinal stenosis, gout, and left tibia fracture, pain, change in cognitive status, visual impairment, mood, incontinence with an intervention of chair/bed-to-chair transfer: The resident is dependent by 1-2 staff. On 12/23/2025 at 10:04 AM, R1 stated that on 11/26/2025, V3 (Licensed Practical Nurse/LPN) and V4 (Certified Nurse Assistant/CNA) had been in the process of transferring her from a shower chair to her bed via mechanical lift. R1 stated, during the transfer, V3 and V4 were having trouble getting the wheels to move on the mechanical lift. R1 stated, while being guided to her bed, elevated in the sling, she could see the mechanical lift starting to tip over. R1 stated, she landed on the floor beside her bed, hitting her bottom and heels on the floor, and the mechanical lift hit her in the head causing a laceration. R1 stated, she had been sent to the local emergency room where she received 2 staples to the top left side of her head. On 12/23/2025 at 10:29 AM, V3 (LPN) stated she had been assisting V4 (CNA) in the afternoon on 11/26/2025 transfer R1 from a shower chair to her bed via mechanical lift. V3 stated, she had been the operator of the mechanical lift while V4 was guiding R1. V3 stated, the mechanical lift had been hard to maneuver with R1 in the sling. V3 stated, during the transfer with R1 elevated in the sling, R1's weight became unbalanced when V4 repositioned R1 for the bed while lift was still in motion causing the mechanical lift to tip over. V3 stated, R1 landed on her buttock in the floor and the mechanical lift hitting R1 in the top left side of her head causing a laceration. On 12/23/2025 at 10:56 AM, V4 (CNA) stated, her and V3 (LPN) had been transferring R1 from a shower chair to her bed via mechanical lift on 11/26/2025 in the afternoon. V4 stated, during R1's transfer she had been guiding R1 while V3 operated the mechanical lift. V4 stated, R1 had been close to the weight limit for the mechanical lift of 450 pounds. V4 stated, while guiding R1 while elevated in the sling she turned R1 to position for the bed, R1's weight became unbalanced causing the mechanical lift to tip over. V4 stated, R1 fell to the floor, hitting her buttock and heels on the ground next to her bed and the mechanical lift hit R1 on the top left side of her head causing a laceration. On 12/24/2025 at 10:45 AM, V4 stated and further clarified that there was a lack of communication between her and V3 during R1's transfer. V4 stated, she had repositioned R1's legs too soon during the transfer while lift was still in motion, which caused the mechanical lift to tip over. On 12/23/2025 at 11:46 AM, V2 (Director of Nursing/DON) stated she had been working the day R1 had fallen with the mechanical lift. V2 stated, V3 and V4 notified her that in the process of transferring R1 from a shower chair to her bed via mechanical lift the lift had tipped over with R1 in the sling causing a laceration to the top left side of her head. V2 stated, the investigation determined that R1's weight became unbalanced during the transfer causing the mechanical lift to tip over. On 12/23/2025 at 11:50 AM, V1 (Administrator) stated she had been notified by V2 that V3 and V4 had been in the process of transferring R1 from a shower chair to her bed via mechanical lift and the lift had tipped over with R1 elevated in the sling causing the lift to hit the top left side of R1's head. V1 stated the investigation determined that R1's weight became unbalanced during the transfer during repositioning and motion of lift and caused the mechanical lift to tip over. On 12/23/2025 at 12:05 PM, V5 (Physical Therapy Assistant/PTA) stated, the mechanical lift could tip over if R1's weight had become unbalanced outside the base center of the mechanical lift during transfer. R1's Progress Note dated 11/26/2025 at 5:55 PM documented R1 was transferring with 2 staff members from shower chair to bed. Resident sustained a fall. Laceration noted to left top of head. Resident sent to ER (emergency room) for evaluation and treat. R1's Progress Note dated 11/26/2025 at 6:30 PM documented R1 returned to facility from local hospital in