STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145518	A. Building B. Wing	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mascoutah Rehab and Nursing	201 South 10th Street Mascoutah, IL 62258

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(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 - Minimal harm or potential for 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 perform safe mechanical lift transfer for 1 of 3 residents (R3) reviewed for accidents in the sample of 6. Findings include: R3's Care Plan, dated 6/13/2025, documents that the resident has potential for falls confusion, deconditioning, Gait/balance problems, incontinence, and poor communication/comprehension, unaware of safety needs. The Care Plan documented Resident had actual falls -6/11/25: Witnessed fall in room out of (full body lift), no injury -1/30/25: Unwitnessed fall in room, no injury. Intervention 6/16/2025 sling with straps for transfers. R3's Incident Report, dated 6/11/2025 at 7:44 PM, documents that Resident transferring per usual from chair to bed by 2 CNAs (Certified Nurse's Aides) using mechanical full lift. During transfer, CNA moved chair out from under resident to position to place in bed. During chair move, resident self-changed position resulting in her rolling through lift straps and onto floor lying on her right side. Resident assessed for injuries; none noted at this time. ROM (Range of Motion) WNL (Within Normal Limits) for resident; baseline contractures to all extremities. Resident shook her head no when assessing for pain. Neuro checks initiated; mental status and movements at baseline and WNL (with in normal limits) for resident. Resident assisted to bed. It also documents that R3 is oriented to person and place, incontinent with no predisposing environmental and situation factors. R3's Nursing Progress Note, dated 6/11/2025 at 10:23 PM, documents Resident transferring per usual from chair to bed by 2 CNAs using mechanical full lift. During transfer, CNA moved chair out from under resident to position to place in bed. During chair move, resident self-changed position resulting in her rolling through lift straps and onto floor lying on her right side. Resident assessed for injuries; none noted at this time. ROM WNL for resident; baseline contractures to all extremities. Resident shook her head no when assessing for pain. Neuro checks initiated; mental status and movements at baseline and WNL for resident. Resident assisted to bed. Resident assessed by nurse; neuro checks initiated. Admin (Administrator), DON (Director of Nursing), and POA (Power of Attorney) notified. MD (Medical Doctor) notified, requested Xray of right shoulder and right hip. POA requested monitoring and notify of any changes as he does not want her to be sent out at this time. Resident to have 3 staff present for all transfers; PT (Physical Therapy) to assess for positioning with transfers. R3's Progress Notes, dated 6/11/2025 at 11:12 PM, documents Orders -Administration Note. Note Text: Tylenol Tablet 325MG (milligrams) Give 2 tablet by mouth every 6 hours as needed for pain. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/2/2025 at 10:00 AM requested transfer and sling assessment. As of 7/8/2025 at 3:00 PM the facility did not provide any assessments. On 6/30/2025 at 9:10 AM V13, R3's Brother, stated that he is R3's guardian. V13 stated that he has concerns about his sister's care at the facility. V13 stated that R3 flipped out of the chair. V13 stated that his sister has been at the facility for 30 to 40 years. V13 stated that he has put a camera in the room because he can't trust the care being given to his sister. V13 stated that on June 11th his sister fell out of the fully body mechanical lift hitting her head on the floor. V13 stated that he has the fall on video. V13 stated that his sister was slouched and side laying in the wheelchair. V13 stated that they lifted R3 out of the chair that way. V13 stated that they didn't bother to fix her before lifting her out of the chair. V13 stated that when they lifted R3 she fell out of the sling. V13 stated that you can hear the staff yell and R3 yell. V13 stated that R3 does not verbalize yes or no. V13 stated that R3 moans, groans, grunts and moves about. On 6/30/2025 at 10:00 AM V13 provided a video to view. V13 verified that the person in the video was R3. The video dated 6/11/2025 at 7:31 PM. During video at 7:35 PM R3 is transported in room by wheelchair by V4, Certified Nurse's Aide (CNA). R3 was observed lying on right side in wheelchair. At 7:36 PM V6, CNA, pushes the full body lift into the room. V6 and V4 assisted with the transfer. V4 placed the wheelchair sideways, with R3's right side facing the lift. V4 and V6 attached the sling hooks to the lift. R3 remained on her right side while in the sling. R3 was not in the center of sling. V6, standing behind the lift and operating the controls, lifts R3 in the air. R3 remained in right side lying position. V4 then removes the wheelchair from beneath R3 allowing R3 to hang in sling without support. V4 then moves the wheelchair away from R3. V4 was not in reach of R3. V6 then pulled the lift back causing the sling to jerk forward and back. R3 then falls face forward out the sling. R3 was heard letting out a yell. R3 feet remained in sling. Then feet fell to floor. On 6/30/2025 at 1:31 PM V4 stated that she was present during the fall with R3 on 6/11/2025. V4 stated that she noticed that R3 was leaning and lying back in chair. V4 stated that R3 was moving in wheelchair and groaning and grunting. V4 stated that this (grunting and groaning) means that R3 is in pain. V4 stated that R3 was uncomfortable and need to lie down. V4 stated that she and V6 assisted R3 with the transfer using the (full body lift). V4 stated that they applied the sling and lifted R3 into the air. V4 stated that once in the air she removed the chair from beneath R3. V4 stated that she did not have a hold of R3 at that time. V4 stated that she was maneuvering the chair and did not see the fall initially. V4 stated that she heard V6 yell and looked up and saw R3 hanging from the lift. V4 stated that she then went to help and R3's body fell to the floor. V4 stated that R3 did hit her head on the legs of the lift. V4 stated that R3 was grimacing, moaning, grunting, and grinding her teeth on the floor. V4 stated that R3 looked in pain. V4 stated that she went and got the nurse, and the nurse took over from there. V4 stated that R3 came out the side hole of the sling. V4 stated that she did not reposition R3 in the chair or sling because she thought R3 was positioned appropriately. V4 stated that she felt the sling was appropriate size. V4 stated that the sling that was used was the one that R3 had under her, not sure of size. V4 stated that she is not sure what determines the size of the lift sling. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/30/2025 at 12:15 PM R4 stated that she was in the room when R3 fell. R4 stated that R3 was slouched down in the chair. R4 stated that the girls attached R3 to the lift. R4 stated that V4 moved the wheelchair back over by R4's bed. R4 stated that V4 was away from R3 and not touching her. R4 stated that she was watching V4 with the wheelchair and then heard a yell and turned. R4 stated then R3 was hanging out the lift with head on legs of lift. R4 stated that the CNAs yelled and V4 was trying to get to R3 and then R3 body fell from lift. On 6/30/2025 at 2:22 PM V6 stated that she and V4 assisted with R3's transfer on 6/11/2025. V6 stated that she was at the controls and V4 had R3. V6 stated that she and V4 applied the straps. V6 stated that R3 was on her back sitting up right in the lift. V6 stated that she lifted R3 out of the chair. V6 stated that V4 removed the chair from under R3. V6 stated that R3 flipped out the side of the sling, face first, hitting head on the legs of the lift. V6 stated that R3 let out a yell. V6 stated that initially R3's legs were still in the sling and then they came out and her body fell to the floor. V6 stated that she felt R3 was in the right sling and positioned correctly. V6 stated that she assumed V4 had a hold of R3 but not sure if she did. On 6/30/2025 at 3:16 PM V12, Registered Nurse, RN, stated that she was the nurse on duty at the time of R3's fall on 6/11/2025. V12 stated that when she entered the room R3 was on the floor. V12 stated that she assessed R3. V12 stated that she did not see any bruising or swelling at that time. V12 stated that R3 was in pain on the floor as she should after hitting her head on the legs of the lift from the air. V12 stated that she notified V1, Administrator and V2, Director of Nursing. V12 stated that she also notified the physician, and a zoom call was performed, and it was determined that R3 didn't require hospitalization at that time. V12 stated that she notified V13 as well and notified him of the fall. V12 stated that V13 did not want R3 to go to the emergency room. V12 stated that they monitored R3 and performed neuro checks. V12 stated that she was informed that while in the lift R3 made a jerking movement and fell out of the sling onto the floor hitting her head and body on the legs of the lift and floor. On 7/2/2025 at 9:20 AM V14, CNA/Shower Aide, stated that she is familiar with R3 and have positioned her. V14 stated that R3 does make jerking movements in her chair and in the lift. V14 stated that you must always have a hold of her during the transfer because she can fall out. V14 stated that at times you need 3 people to help with the transfer. V14 stated that R3 requires the lift sling that crosses between the legs. V14 stated that this is the appropriate lift for her. V14 stated that the brother doesn't like the sling. V14 stated that she uses the sling anyway because it's the safest for her. V14 stated that the resident needs to be sitting up right as much as possible while in the lift. V14 stated that if the resident is not then they are lowered in the chair, repositioned, and then transferred. V14 stated that the slings are determined by size and weight. On 7/2/2025 at 9:33 AM V16, CNA, stated that she has transferred R3 multiple times. V16 stated that R3 makes these movements. V16 stated that R3 will be stretched out then she will randomly draw her feet up in a jerking movement. V16 stated that R3 will be in the fetal position and then will stretch out. V16 stated that none of these movements are slow. V16 stated that it is scary at times lifting R3. V16 stated that when R3 is moving in the bed or in the chair, V16 stated that she gets a 3rd and sometimes 4th person. V16 stated that its safer because she will have these movements, and it will cause the sling to move, and I am afraid of her falling out of the sling. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/2/2025 at 10:00 AM V1, Administrator, stated that the conclusion of the fall from what was told to him is that R3 was agitated in the wheelchair and during the transfer. V1 stated that the staff lifted the R3 in the air, using the lift. R3 move in the lift and R3 fell to the floor, hitting her head on the legs of the lift. V1 stated that he and V2, Director of Nursing, were notified and performed a zoom call while R3 was on the floor and had the staff describe what happened. V1 stated that he did not ask if the staff was in contact with the resident during the transfer. He assumes that they were. On 7/2/2025 at 10:15 AM V3, Assistant Director of Nursing (ADON (Assistant Director of Nursing)) stated that R3 is challenging at times in the lift. V3 stated that R3 makes jerking movements and moves in the lift. V3 stated that R3 makes these movements in her chair as well as causing her to slide down in her chair. V3 stated that when R3 is like this it is challenging to transfer R3. V3 stated that the transfer is scary because R3 could fall out of the chair. V3 stated that when R3 is like that they will use a 3rd person. V3 stated that she has transferred R3 and due to her movements, she had to be repositioned in the chair and in the sling prior to transfer. V3 stated that this is to assure R3's safety. V3 stated that is R3 was in a lying position he would expect the staff to reposition R3 in her wheelchair prior to attaching the lift. V3 stated that once in the air of R3 was not positioned appropriate in the sling she would expect the staff to reposition R3. V3 stated that if that was not possible, she would expect the staff to get a 3rd person to assist in the transfer. V3 stated that the staff are aware of these movements with R3 and that they can always add people with the lift and always maintain contact with the resident during the transfer. On 7/8/2025 at 11:50 AM V19, Therapy Director, stated that R3 was seen after fall. V19 stated that an evaluation was completed, and they work on transfer safety. V19 stated that the staff were in serviced. V19 stated that R3 is to have 3 staff for transfers. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The (Brand name of mechanical lift) PATIENT SLING REFERENCE GUIDE, not dated, documents Patient Sling Guide It is very important to use the correct sized sling and make sure it is fitted properly prior to lifting. This ensures the safety of both the person being lifted and the caregiver. The goal of this guide is to assist those responsible for selecting the correct sling on a patient by patient basis and outlines a few factors that need to be addressed in the selection of the appropriate type of sling for a patient. (Brand name of mechanical lift company) wishes to ensure that the task of moving patients is done in an effective and safe manner. Size & Weight Range Guide (approximately). Please note the following sling guide is a recommendation only. A full risk assessment must be done prior to any sling being selected. This will ensure safety for the patient and caregiver. Small (S) 75- 150. 59 - 64. (The Brand name of mechanical lift company) Owner's Manual, not dated, documents that Transfer From Wheelchair - Grasp the sling at each corner of the U shape of the commode aperture. - The sling should be fitted with the handle on the back section facing outward. - Help the user lean forward slightly, then slide the sling down between the chair and the user's back. - Position the commode aperture where the buttocks meets the seat. - Position the sling equally around both sides of the body. - Draw the leg sections to the front along the length of the user's thigh. - Check the sling's central positioning by comparing the lengths of the leg sections when they are drawn forward. - Reposition the sling if the leg sections are not equal in length. - Feed the leg sections under the thighs. o From between the legs, gently pull the leg section up the inner thigh. - Feed as much material as possible under and between the thighs. - Ensure the leg sections are positioned midway under the thighs to provide good support and greater comfort. - Move the lift slowly towards the user and position the spreader bar over the user's chest. - Attach Loop a of sling to Hook A on Spreader Bar; attach Loop b to Hook B; attach Loop c to Hook C; attach Loop d to Hook D. - Lift patient above the wheelchair by using the hand control. - Pull lift away from wheelchair. Position patient over bed and lower patient onto it. SAFETY INSTRUCTIONS: Please pay careful attention to the following important information regarding the care, maintenance, and operation of the (Brand name of full body mechanical lift). Carefully read these instructions before assembling the lifter or attempting to lift any user with the device. PLEASE NOTE THE FOLLOWING: - Special care must be taken with users/patients who cannot themselves provide assistance while being lifted. (i.e. patients who are comatose, spastic, agitated, or otherwise severely handicapped.) - While being lifted in a sling, always keep the user/patient centered over the base and facing the caregiver operating the lifter.