STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146114	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lena Living Center	1010 South Logan Street Lena, IL 61048

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41639 Based on interview and record review, the facility failed to perform safe bed mobility for 1 resident (R1) reviewed for safety and supervision. This failure resulted in R1 sustaining a nasal bone fracture, a femoral neck fracture, and a 4x4cm (centimeter) laceration to her forehead that was repaired with 9 sutures. This applies to 1 of 3 residents reviewed for safety and supervision in the sample of 3. The findings include: R1's electronic face sheet printed on 8/1/24 showed R1 has diagnoses including but not limited to intracapsular fracture of right femur, localization-related idiopathic epilepsy and epileptic syndrome with seizures, laceration of head, dementia with agitation, and osteoporosis. R1's facility assessment dated [DATE] showed R1 has severe cognitive impairment and requires 2+ staff assist for bed mobility. R1's ADL (Activities of Daily Living) assessment dated [DATE] showed R1 requires 2+ staff physical assist for bed mobility. R1's local hospital records dated 7/28/24 showed, Patient is bedridden at baseline and lives at (facility), was getting bed bath done today by staff with bed raised high, patient rolled out of bed resulting in a 3x3cm laceration to forehead, blood from nares, right leg pain with hip flexion .Head exam- 4x4cm linear laceration over the frontal area of the skull through the epidermis .patients imaging studies were reviewed .there is questionable chip fracture of the nasal bone, a displaced sub capital fracture of the right femoral neck . Procedures: laceration wound explored, irrigated extensively, deep structures intact, size: 4cm, number of sutures: 9. On 8/1/24 at 8:57AM, V6 (Certified Nursing Assistant) stated, (R1) has a hip fracture, a broken nose, a cut on her forehead and some bruising. I don't know what happened to her. She has always been a 2 assist for bed mobility because she doesn't help very much so if you were to use one person you would really have to give some momentum to get her over on her side. She can be very unpredictable and she has had seizures before so you have to have 2 people with her no matter what. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Actual harm Residents Affected - Few	On 8/1/24 at 9:35AM, V4 (Certified Nursing Assistant) stated, I was giving (R1) cares and washing her buttocks and had her rolled on her side with one of my hands on her hip and cleaning her with the other hand. She had a jerking movement and the momentum flung her forward and she landed on the floor on her stomach. I had the bed at about my waist level so it wasn't all the way up but it definitely wasn't low to the floor. I immediately went and got the nurse and she had me hold pressure on (R1's) forehead while she called 911 and we stayed with her until the ambulance arrived. I was scheduled on the hall by myself but I know to ask for help, I just didn't. This was so scary and I never anticipated anything like this would happen. I was just trying to get her cleaned up by myself and I didn't know she would jerk forward like that. I know she is supposed to be a 2 person assist for bed mobility but I did it by myself anyway. On 8/1/24 at 11:23AM, V2 (Director of Nursing) and V3 (Assistant Director of Nursing) stated, (V4) definitely should have had another aide helping her with (R1's) bed mobility. There were several other aides in the building at the time and we all have walkie talkies to call someone for help when we need it. Even the nursing administration has the walkie talkies so we can help when needed. If a resident requires 2 people for bed mobility then it's obviously not safe to use 1 person because they have been assessed as needing 2 people. This was a bad judgement call for (V4) and we have in-serviced her and the other aides on bed mobility assistance. This could have been prevented if she would have asked another aide for help. The facility's policy titled, Activities of Daily Living dated 2/17/20 showed, It is the policy of this center to assure residents have their activities of daily living needs met in a person-centered manner. The center will strive to assure residents maintain and or improve their current level of ADL function.