STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E306	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Aurora Living & Rehab Ctr	310 Banbury Road North Aurora, IL 60542

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** 48944 Based on interview and record review the facility failed to safely transfer a resident (R1) with the use of a mechanical lift. This failure resulted in the resident falling and sustaining fractures to the right hip, left pelvis, pubic bone, and lumbar vertebra. This applies to 1 of 3 residents (R1) reviewed for accidents. The findings include: R1's EMR (Electronic Medical Record) showed R1 was admitted to the facility on [DATE] with multiple diagnoses including generalized edema, chronic pain, impaired mobility, and generalized weakness. R1's MDS (Minimum Data Sheets) dated 3/19/2025 shows R1 was dependent on staff for transfers and required the use of a mechanical lift. On 4/07/2025 at 11:25 AM, V6 (Certified Nurse Assistant/CNA) was interviewed regarding R1's fall incident on 3/31/2025. V6 said she secured R1's sling to the mechanical lift to transfer him from the bed to his wheelchair. V6 said V4 (CNA) then came to the room and stood behind R1's wheelchair as she started to operate the lift. V6 said she started to maneuver the machine as V4 remained behind the wheelchair (not within close reach of R1). V6 said she then started to turn the machine when the sling's lower left strap suddenly ripped and R1 fell to the floor. V6 said R1's sling was worn out from overuse because it had not been replaced since R1's admission. On 4/07/2025 at 9:45 AM, V4 (CNA) said she was asked to assist V6 with R1's transfer on 3/31/2025. V4 said that when she arrived at R1's room V6 had already connected R1's sling to the lift. V4 said she positioned herself behind R1's wheelchair (not within close reach of R1) to receive him while V6 started to maneuver the machine. V4 said R1 fell as V6 started to turn the machine because the sling's lower left strap ripped. V4 said they were unable to respond quickly to reduce R1's fall impact from the mechanical lift. (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	On 4/07/2025 at 2:00 PM, V2 (Director of Nursing/DON) said she responded to R1's fall incident. V2 said R1 had to be transferred to the hospital because he was complaining of pain to his back, legs, and elbows. V2 said she interviewed V6 and V4 after the incident and assessed R1's sling. V2 said the sling's lower left and right straps were ripped completely in half. V2 said she had concluded that R1's fall was because the sling's straps were frayed causing them to rip during R1's transfer. V2 continued to say R1's sling appeared worn out from overuse. V2 said R1's sling should have been inspected before being used and tossed because it was unsafe for use. V2 also said she expects both staff members to be actively assisting with mechanical lift transfers to ensure safe transferring and be able aid in an emergency. On 4/07/2025 at 3:00 PM, V12 (Nurse Practitioner/NP) said R1 required total assistance with mobility and transfers. V12 said R1 required the use of the mechanical lift for transfers and expected the staff to be trained on how to safely use the lifting equipment to ensure safe transfers. V12 also said the facility was expected to maintain operable lifting equipment based on policy or manufacturing guidelines to ensure residents were provided with safe equipment. R1's Care Plan Activity Report with a review date of 1/03/2025, showed R1 was at risk for falls and required staff assistance with transfers. R1's transfer focus problem had multiple interventions, including Assist with safe transfers as recommended: [Mechanical] lift and 2-person assist, Provide equipment for transfers: [Mechanical] lift, and Utilize mechanical lifts as appropriate. R1's progress note dated 3/31/2025 shows At about 1140, the writer was notified that the resident had a witnessed fall during transfer with a [Mechanical] life from bed to wheelchair .Resident complained of pain 7/10 on his legs, back, and elbows .911 was called and they arrived and took him out to [Hospital] ER. R1's Accident Investigation Form dated 3/31/2025, shows R1's fall occurred because the sling broke. The form said the sling should have been inspected before being used to transfer R1 on 3/31/2025. R1's Fall Incident Final Report dated 4/04/2025 shows During the [Mechanical] lift transfer, resident suddenly fell to the ground on his buttocks .The CNA who navigated the resident stated that the fall happened so quickly that she didn't have time to reach to reduce the impact .Upon further investigations, both bottom loops of the sling were fray apart. R1's hospital notes dated 3/31/2025 shows R1 was brought from nursing facility for evaluation of a fall. Reportedly the [Mechanical] lift broke and he was dropped on the ground. Patient reports pain in his neck, back, hip, and legs. Pain is constant, worse with movement. Images showed closed right acetabular fracture; Fracture of left ischium, Pubic bone fracture, Fracture of the transverse process of lumbar vertebra. The facility's policy titled Hydraulic Lift dated 08/2024, shows Purpose To enable two staff to lift and move a resident safely, with little effort as possible. The policy does not provide instructions on equipment checks before use, including slings. The facility's policy titled Resident Supervision Policy dated 07/2024, shows To ensure the facility provides an environment that is free from accident and hazards over which the facility has control and provide supervision and assistive devices to each resident to prevent avoidable accident. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The facility's provided [Mechanical] lift manufacture's document titled Manual/Electric Portable Patient Lift undated, said Transferring to a Wheelchair . [Company] recommends that two assistants be used for all lifting preparations, transferring from and transferring to procedures .Maintenance .SLINGS AND HARDWARE CHECK ALL SLING ATTACHMENTS each time it is used to ensure proper connection and patient safety. Inspect sling material for wear. Inspect strap for wear.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48944 Based on interview and record review, the facility failed to follow manufacturer's maintenance recommendations for the safe use of a mechanical lift-sling transferring device. This applies to 1 of 3 (R1) residents reviewed for transfer equipment. Findings include: R1's EMR (Electronic Medical Record) showed R1 was admitted to the facility on [DATE] with multiple diagnoses including generalized edema, chronic pain, impaired mobility, and generalized weakness. R1's MDS (Minimum Data Sheets) dated 3/19/2025 shows R1 was dependent on staff for transfers and required the use of a mechanical lift. On 4/07/2025 at 11:25 AM, V6 (Certified Nurse Assistant/CNA) said on 3/31/2025 she and V4 (CNA) transferred R1 from the bed to his wheelchair. V6 said she secured R1's sling to the mechanical lift. V6 said she then started to maneuver and turn the machine when the sling's lower left strap suddenly ripped and R1 fell on the floor. V6 said R1's sling was worn out from overuse because it had not been replaced since R1's admission. On 4/07/2025 at 9:45 AM, V4 (CNA) said she was asked to assist V6 with R1's mechanical lift transfer on 3/31/2025. V4 said R1 fell as V6 started to turn the machine because the sling's lower left strap ripped. V4 said they were unable to respond quickly to reduce R1's fall impact from the mechanical lift. V4 said R1's sling was old and worn out from overuse. V4 said R1's sling had not been replaced for years. On 4/07/2025 at 2:00 PM, V2 (Director of Nursing/DON) said she responded to R1's fall incident. V2 said she interviewed V6 and V4 after the incident and assessed R1's sling. V2 said the sling's lower left and right straps were ripped completely in half. V2 said she had concluded that R1's fall was because the sling's straps were frayed causing them to rip during R1's transfer. V2 continued to say R1's sling appeared worn out from overuse. V2 said R1's sling should have been inspected before being used and tossed because it was unsafe for use. V2 said the facility did not have a policy for maintaining lift sling equipment. V2 said she was not aware of the sling's manufacturing service life recommendations. On 4/07/2025 at 3:00 PM, V12 (Nurse Practitioner/NP) said R1 required the use of the mechanical lift for transfers. V12 said the facility was expected to maintain operable lifting equipment based on policy or manufacturing guidelines to ensure residents were provided with safe equipment. R1's Care Plan Activity Report with a review date of 1/03/2025, showed R1 was at risk for falls and required staff assistance with transfers. R1's transfer focus problem had multiple interventions, including Assist with safe transfers as recommended: [Mechanical] lift and 2-person assist, Provide equipment for transfers: [Mechanical] lift, and Utilize mechanical lifts as appropriate. R1's Accident Investigation Form dated 3/31/2025, shows R1's fall occurred because the sling broke. The form said the sling should have been inspected before being used to transfer R1 on 3/31/2025. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Fall Incident Final Report dated 4/04/2025 shows During the [Mechanical] lift transfer, resident suddenly fell to the ground on his buttocks .The CNA who navigated the resident stated that the fall happened so quickly that she didn't have time to reach to reduce the impact .Upon further investigations, both bottom loops of the sling were fray apart. The facility's policy titled Resident Supervision Policy dated 07/2024, shows To ensure the facility provides an environment that is free from accident and hazards over which the facility has control and provide supervision and assistive devices to each resident to prevent avoidable accident. The [Mechanical] lift's manufacturer's document titled Patient Slings undated, said SPECIAL NOTES . Service Life The expected service life is thirteen (13) months for this product, provided the product is used in accordance with the intended use as set out in this document .General Guidelines After each laundering (in accordance with instructions on the sling), inspect sling(s) for wear, tears, and loose stitching. Bleached, torn, cut, frayed, or broken slings are unsafe and could result in injury. Discard immediately.