STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000772	A. BUILDING: _____ B. WING _____	C 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON HILL	2400 SOUTH FINLEY ROAD LOMBARD, IL 60148

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S 000	Initial Comments Facility Reported Incident of August 31, 2021/IL137932	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1	S9999		

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

These requirements were not met as evidenced by:

Based on observation, interview, and record review, the facility failed to transfer a resident with a mechanical lift in a safe manner.

This failure resulted in one of the fabric loops coming off the hook on the lift which caused R1 to fall backwards out of the lift sling, sustaining a cervical fracture and a head laceration.

This applies to 1 of 3 residents (R1) reviewed for transfers/fall in the sample of 3.

Findings include:

Facility incident report for R1, dated 8/31/21 at 11:16 AM, notes that the nurse was called to room by CNA (Certified Nurse Assistant). CNA stated that R1 slid out of mechanical lift sling, hitting her head on the floor. A pressure dressing was applied to a small head laceration. R1 was assessed and sent to the Emergency Room for evaluation. Follow-up note on the incident report documents R1 was being transferred from the bed to the reclining chair using a mechanical lift,

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S9999	Continued From page 2 sling and 2 staff. During the transfer, R1, who is a 91-year-old resident on Palliative care, slipped from the lift headfirst and hit her head on the floor, after falling approximately 3 feet. R1 did not lose consciousness. There was a small, open area noted to the back of her head. R1 was assessed by the nurse who applied a pressure dressing to the head laceration. An ambulance was called and required notifications were made. R1 was transferred to the hospital for evaluation. Additional notation indicates R1 returned to the facility the same day. R1 was re-admitted with a fracture involving the inferior articulating facet of C6 (6th cervical vertebra) on the left, with normal alignment. The laceration to the right side of the back of R1's head was noted with 2 staples. Orders included R1's same medications including Tylenol and Morphine for shortness of breath or agitation. R1's POA (Power of Attorney) arrived and stated that she had not wanted any aggressive treatment at the hospital. R1 appeared calm and comfortable, according to this report. The report does note that staff had been inserviced on the use of the mechanical lift safety via skill check. R1 was to remain on bedrest for a period of time. On 9/9/21 at 11:50 AM, V3 (CNA) stated she was caring for R1 on the day of the incident, and she was assisting with R1's transfer. She was familiar with R1 and had transferred R1 other times using the mechanical lift without problem. V4 (CNA) was also helping her with the transfer. They both assisted with placing the sling under R1, by turning R1 from side to side; each connected their side of the sling to the hanger bar using the fabric loops and hooks. They didn't have any problems hooking the sling to the overhead hanger bar. They noted no problem with either the sling or the lift. After the sling was in place, V4	S9999		

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S9999	Continued From page 3	S9999		

went to the head of the bed to operate the lift and V3 went to the foot of the bed with the reclining chair. V4 used the remote and began to slowly lift R1 off the bed. Initially there was no problem, then V4 again used the remote and began to swing R1 out to the side of the bed. V3 stated she was trying to get the chair in position under R1, and suddenly, the sling tilted and R1 fell backwards out of the sling, headfirst, falling to the floor. She yelled a little and was not unconscious. V3 stated she could not recall if she had either of her hands on R1 while she was lifted off the bed or being swung in the sling to the side of the bed, because she had been trying to position the chair. V3 stated the fall happened very fast and she couldn't steady R1. They kept her on the floor and remained with her while another staff member called the nurse. R1 was sent to the hospital. V3 could not recall when she had last been trained in use of the mechanical lift. There was an in-service on safe use of the mechanical lift since this incident, but she was off and did not attend. V3 stated V4 was operating the lift, so V4 would not have been able to have her hands on R1 during the transfer.

On 9/9/21 at 12:50 PM, V4 (CNA) confirmed that she was assisting V3 with R1's transfer on 8/31/21. V4 also confirmed no problems with either the sling or the lift while they were placing the sling under R1 and hooking the sling to the overhead hanger bar. V4 stated the overhead hanger bar was mobile and able to tilt. After hooking the sling to the overhead hanger, V4 went to the head of the bed to operate the lift remote. V3 went to the foot of the bed to position the reclining chair. V4 used the remote and began to lift R1 off the bed slowly. V4 stated that residents are to be on their back in the sling, but she noted that R1 was leaning somewhat to the

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S9999	Continued From page 4 side. R4 stated they tried to position her on her back. According to V4, R1 tends to roll herself up into a ball; she tends to lean to one side. V4 thinks she leans to the right. V4 then moved R1 slowly out to the side of the bed. V4 stated V3 was about to place the reclining chair under R1, who was now at the side of the bed, when suddenly a corner of the sling came loose from the hook on the hanger bar because the overhead bar tilted. V4 explained 1 of the 4 corners of the sling, the corner nearest V4, the top right corner, came off the hook causing R1 to suddenly fall backwards headfirst. V4 described R1 as tilting back out of the sling. Neither V3 or V4 had their hands on R1 at the time of the fall. V4 was operating the remote on the lift and V3 was positioning the chair. V4 has been trained on the use of a mechanical lift but could not remember when her last training was prior to this incident. V4 attended an in-service on general safety during use of the mechanical lift since the incident occurred. On 9/9/21 at 3:45 PM, V6 (ADON) stated V6 and V2 (DON) were in a meeting together when V2 was notified of R1's fall. They both immediately examinee the lift and the sling to determine if there was any problem with the equipment. V6 stated they did not find any problem with either the lift or the sling; nothing was broken, and the sling was intact. V6 stated R1 was a hospice resident and the lift and sling had been provided by the hospice company. V6 stated she spoke to both staff involved, and they reported no problem with the equipment. V6 and V2 made the decision to remove the lift from use. V6 asked V3 and V4 to re-enact the transfer and show her where each of them was positioned. V6 stated V4 was at the head of the bed with the lift, and V3 went to the foot of the bed to position the reclining chair. V3	S9999		

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S9999	Continued From page 5 and V4 showed V6 that the hanger bar, which is the piece of the lift that the sling is hooked to, tilted, going from a horizontal plane to an almost 90-degree vertical plane. V6 stated there should have been 1 person operating the lift and the other guiding the resident into the chair; that is the purpose of having 2 people transfer someone with a lift. V6 initially stated she wasn't clear after talking to both staff that neither were guiding R1 while in the sling. After learning V4 had stated neither of the CNAs had their hands on R1 during the transfer, V6 told V4 there should have been guidance of R1 during this transfer. V6 stated when the hanger bar swings, the loop could come off the hook, because it is an open hook, not totally closed. V6 stated when she interviewed V3 and V4, their statements were very similar. Both statements, contained in R1's incident report investigation, indicate that one staff was steering the lift and the other was positioning the reclining chair. R1's upper body was off the bed; her legs were not supported but remained on the bed. The arm tilted and R1 slid out of the sling. Hospital Emergency Room record for R1, dated 8/31/21, confirms fracture involving the inferior articulating facet of C6 on the left, as well as a head laceration treated with 2 staples. Ambulance record of the same date reflects that the paramedics were called to transport R1 to the hospital as the result of a fall. Page 10 of the user manual for this lift, under a section entitled "Transferring the Patient" "Warning", states "When elevated a few inches off the surface of the stationary object...and before moving the patient, check again to make sure that the sling is properly connected to the	S9999		

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S9999	Continued From page 6 hooks of the hanger bar. If any of the attachments are not properly in place, lower the patient back onto the stationary object...and correct the problem". Page 5 of the user manual, under a section entitled "Warning", states, "Warning indicates a potentially hazardous situation which, if not avoided, could result in death or serious injury". (A)	S9999		