STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006274	A. BUILDING: _____ B. WING _____	09/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HILL	623 HAMACHER STREET WATERLOO, IL 62298

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1210 b)5) 300.1210 c)6) 300.3240a) 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. Restorative measures shall include, at a minimum, the following procedures: 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 6) All necessary precautions shall be taken to assure that the residents' environment remains	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Regulatios were not met as evidence by: Based on interview, record review, and observation the facility failed to provide safe transfers to prevent falls for 2 of 17 residents (R4, R117) reviewed for falls in the sample of 49. This failure resulted in R117's falling and sustaining a right elbow fracture. Findings Include: 1. R117's Minimum Data Set (MDS) dated 9/1/22 documents R117 is cognitively intact and requires Extensive Assistance with 2 person physical assist in transfer; moving from seated to standing position-not steady, only able to stabilize with staff assistance; surface-to-surface transfer-not steady, only able to stabilize with staff assistance. R117's Face Sheet undated documents R117 diagnoses as Hemiplegia, unspecified affecting right dominant side, Muscle weakness, Aphasia following cerebral infarction. On 09/13/22 at 3:46 PM, R117 stated An agency Certified Nursing Assistant (CNA), got her (R117) right arm in the bed side rail when the CNA tried to help (R117) out of bed. R117 stated, "The CNA	S9999		

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S9999	Continued From page 2	S9999		

did not know what she was doing. After I slid to the floor with my arm caught in the side rail, the CNA left me. I started yelling for help. It happened around 8:45 AM. I was taken to a local hospital. The staff are getting me up tomorrow using the mechanical body lift."

The Fall Investigation dated 9/12/22 documents R117 was lowered to the floor from bed. Complaining of right side of temple pain and right elbow pain. R117 was sent to local emergency room (ER). The agency CNA interviewed stating she left R117 on the side of bed with her legs dangling off bed and upper body lying back on bed to get someone to help her with the transfer of R117. The staffing agency was contacted, and the CNA was placed on the Do Not Return (DNR) list. R117 returned to the facility with right elbow fracture.
Corrective Action: Interdisciplinary Team (IDT) recommendation dated 9/12/22 Make sure 2 staff members, lift, bed to floor.

A undated note attached to the 9/12/22 Fall Investigation from the CNA involved, documents, "I came in (R117's) room to get her ready for breakfast I started to sit her up but I needed assistance I left her (R117). She (R117) had her legs on the side of the bed partially laying back and when I made it back to her room nurses where in her room and she said she fell on the floor."

On 9/15/22 at 2:40 PM, V24, CNA, states, "Yes, I was here that day that the fall happened. Everyone knows (R117) is a 2 person assist. It was an agency CNA and did not take her time. She wanted to rush and get things done but you can't rush through everything. We all convened to (R117's) room when (R117) called out for help."

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S9999	Continued From page 3 On 9/16/22 at 11:30 AM, V2, Director of Nursing (DON) states, "To avoid things like this we have care cards in each residents room because we want staff to know to care for our residents. It was also there because we do hire agency staff and it was there to help them. My expectations are that they would follow the care cards to avoid problems like this. My expectations are that all staff follow the care cards." R117's Hospital records dated 9/12/22 documents diagnosis: closed non displaced fracture of the right radius. (B)	S9999		