STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007868	A. BUILDING: _____ B. WING _____	C 03/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA AT SOUTH HOLLAND, THE	16300 WAUSAU STREET SOUTH HOLLAND, IL 60473

(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 Facility Reported Incident of February 7, 2022 IL144773	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210 a) 300.1210 b) 300.1210 d)6) Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. 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	S9999	**Attachment A** Statement of Licensure Violations	

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S9999	Continued From page 1	S9999		

care needs of the resident.

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 are not met as evidenced by:

Based on observation, interview, and record review, this facility failed to follow its mechanical lift device protocol when transferring one resident (R5) from bed to wheelchair out of three residents reviewed for mechanical lift device required for residents totally dependent on staff for safe transfers. This failure resulted in R5 sustaining lumbar spine transverse process fractures at L3, L4, and L5.

Findings include:

Review of R5's medical record notes R5 was admitted to this facility on 2/5/2022, with diagnoses including: displaced fracture left patella (knee) with knee immobilizer in place, COPD (chronic obstructive pulmonary disease), diabetes. heart failure, high blood pressure, unsteadiness on feet, and weakness.

Review of R5's BIMS (Brief Interview of Mental Status) score is 14 out of 15.

Review of R5's ADL (activities of daily living) care plan notes for transfers R5 is total dependence,

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S9999	Continued From page 2 requires mechanical lift device. Review of R5's hospital record, dated 2/10/2022, notes R5 presented to the emergency room with complaints of lower back pain following fall. R5 stated R5 was on a mechanical lift device when R5 fell down on his tailbone. R5 stated R5 was unable to complete dialysis treatment on 2/10 due to lower back pain. CT (computerized tomography) scan of lumbar vertebrae noted left spinous process fractures at L3 (3rd lumbar vertebrae), L4, and L5. Review of R5's hospital discharge instructions, dated 2/10/22, notes bones of the spine (vertebrae) have portions that extend off to either side of the spine. These portions of bone are called transverse processes. A transverse process fracture which is also called a rotation spine fracture is a break in a transverse process. This kind of fracture results from a sudden and severe bending of the spine to one side. On 3/24/2022, this surveyor observed the mechanical lift device on the nursing unit. The lift device has signage affixed near the controls for the lift device noting: Caution lift patient ONLY with lifter legs in wide position to prevent chance of tipping. On 3/25/2022 at 9:30am, V5, CNA (Certified Nursing Assistant) stated on 2/7/22, V5 assisted another CNA with transferring R5 from bed to wheelchair using a mechanical lift device. V5 stated the lift device started tipping over once they removed R5 from bed. V5 stated V5 tried to prevent R5 from falling by attempting to catch the lift device, but when V5 was unable to keep lift device upright, both CNAs lowered R5 to the floor. V5 stated the legs of the lift device are kept	S9999		

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S9999	Continued From page 3 in the widened position while lifting resident off bed until resident is in wheelchair. V5 stated during this transfer, the legs on the lift device were in the narrowed position. On 3/25/2022 at 12:20pm, V6, CNA, stated V6 was assigned to provide care for R5 on 2/7/22. V6 stated R5 had to go to dialysis, so V6 asked V5, CNA, to assit with getting R5 into wheelchair. V6 stated a mechanical lift device was used to transfer R5 from bed to chair. V6 stated the sling was placed under R5 and the straps connected to the lift device. V6 stated V6 was holding the wheelchair while V5, CNA, operated the lift device. V6 stated V5 pulled the lift device legs out from under the bed and was trying to position lift device between the wheels of wheelchair. V6 stated the device started tilting forward. V6 stated V5 tried to push device upright, but due to the weight of R5 and the weight of the device, V5 was unsuccessful. V6 stated V6 moved the wheelchair out of way and both CNAs lowered R5 to the floor. V6 stated when the legs of the lift device are pulled out from under bed, the legs are in the widened position. V6 stated you need to close the legs narrow when positioning it. V6 stated the device is more stable when the legs are widened. On 3/29/2022 at 7:55am, V12 (Restorative Aide) stated V12 is responsible for training staff on mechanical lift device protocols. V12 stated the legs of the mechanical lift device remain widened throughout the transfer of a resident from bed to chair or vice versa. V12 stated this ensures the lift device does not tip over; it keeps the device stable. V12 stated two staff are required for all transfers with a lift device. V12 stated one staff member operates the controls and steers the device while the other staff member should be	S9999		

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S9999	Continued From page 4 standing next to the resident to guide the resident into the chair. V12 stated V5 and V6 were re-educated and competencied after this event. (A)	S9999		