STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005961	A. BUILDING: _____ B. WING _____	C 07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMWOOD NURSING & REHAB CENTER	152 WILMA DRIVE MARYVILLE, IL 62062

(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 Complaint Investigations: 2245337/IL148798 & 2245290/IL148744	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1210b) 300.1210c) 300.1210d)6 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 that each resident receives adequate supervision and assistance to prevent accidents. These Requirements were NOT MET as evidenced by: Based on observation, interview, record review, the facility failed to provide safe transfers for 1 of 4 residents (R2) reviewed for incidents/accidents in the sample of 4. This failure resulted in R2's fall from mechanical lift sustaining fractures of the left lower leg. Findings Include: R2's facesheet documents diagnosis of Quadriplegia, Cerebral Palsy, Scoliosis. R2's Minimum Data Set (MDS), dated 7/4/2022 documents R2 is cognitively intact. MDS documents R2 requires extensive 2 person assist with ADLs (activities of daily living). R2's fall investigation, dated 6/7/2022, documents R2 had a fall in his room while being transferred via mechanical lift. R2 was immediately assessed and sent to ER for treatment. Hospital called with results of rays which were: possible minimally displaced fracture of the posterior tibia plateau and proximal fibular head (bones of the lower leg). R2's progress notes dated 6/07/2022 7:20 PM document R2 to be returning to facility. Diagnosis of Minimally displaced Left TB (tibia)/Fib (fibula) Fracture. R2's fall risk assessment dated 6/8/2022 documents R2 is at risk for falls.	S9999		

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S9999	Continued From page 2	S9999		

R2's care plan updated 6/8/22 documents R2 has experienced an actual fall on 6/7/22.
R2 requires follow up care as indicated related to injury until healed. InterDT (interdisciplinary team) to review fall and provide interventions as indicated. Therapy to screen related to fall and provide treatment as indicated.

On 7/8/2022 at 9:00AM, R2 stated "They used the wrong sling to lift me up. They used a 3 prong and I am supposed to use the 4 prong. I could tell as soon as they starting lifting me it wasn't right. I was just off the bed a little and hit my head and broke my leg. I slid out of the sling. I was at the hospital all day."

On 7/12/2022 at 9:00AM, V1, Administrator, stated "(R2) sat up and that's what happened when he fell out of the sling. (V12, Certified Nursing Assistant- CNA) and (V13, CNA) was transferring him and the straps on the sling weren't crossed. I showed (R2) this. His Xray showed several small fractures which may be pathological since they were very small."

On 7/8/2022 at 11:20AM, V2, Director of Nursing (DON), stated "(R2) was being assisted up with the mechanical lift by (V12) and (V13). (R2) leaned forward and (V12) and (V13) couldn't catch him. Even though he is paraplegic he is able to sit up. He even said he sat up and slid out of the sling. (V10, CNA) worked here briefly and she is who told (R2) that (V12) and (V13) had attached the sling wrong. The sling was not attached wrong. They had not crossed the straps. The slings and mechanical lifts are universal. I completed the report and have nothing to hide."

On 7/12/22 at 1:03 PM, V13 stated, "I went in to get (R2) and he did not want to get up, but I

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S9999	Continued From page 3 encouraged him to get up, so I put him in sling and it must have been too big for him but when we raised him up I was holding under his buttock and when she pulled the lift back (R2) lifted up and that made him go forward out of the sling. I tried to catch him but couldn't. I think maybe if he had a smaller sling that wouldn't have happened. The straps were all in the 4 corners. We could not have crossed the straps because with his wound it would have hurt him." On 7/12/22 at 2:00 PM, V12 stated I was with another resident across the hallway and (V13) called over for me to assist with (R2). When I went over there, (R2) was already hooked up to the machine, so I grabbed the remote control and (V13) was supporting his bottom half. The sling had three on each side and the bottom one that is supposed to be between his legs was not there and that's how he slid out. By the time I realized it, (R2) was already sliding out." Facility fall policy with a revision date of March 2018 states "The nursing staff in conjunction with the attending physician, consultanting pharmacist, therapy staff and others will seek to identify and document residents at risks for falls and establish a resident centered falls preventions plan based on relevant information." It also documents, "Based on previous evaluation and current data the staff will identify interventions related to the resident's specific risks and causes to prevent the resident from falling and to try to minimize complications from falling." (B)	S9999		