STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001176	A. BUILDING: _____ B. WING _____	R-C 04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON CARE AND REHABILITATION	4538 NORTH BEACON CHICAGO, IL 60640

(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 Survey 2381996/IL157338	S 000		
S9999	Final Observations Statement of Licenure 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 and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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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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 interview and record review the facility failed to safely transfer one out of three residents (R1) from the bed to wheelchair out the sample reviewed for falls. This affected R1 who was transferred from bed to wheelchair with a housekeeper physical assistance. As a result, R1 sustained injury to the 4th and 5th to toe and was bleeding. This has the potential to affect 90 of the residents residing in the facility.

Findings include:
On 04/11/23 at 10:46am R1 noted in bed complained to the surveyor that about two Fridays ago (R1) was injured during transfer. R1 stated that the housekeeper transferred (R1) with other CNA and injured R1). R1 stated I was in severe Pain for days that I had to take (NORCO) for the pain. The surveyor asked at what level is your pain from a scale of 1 to 10. R1 replied 20 because I was in serious pain and bleeding. They (Facility) did the X-ray, but it returned that there was no fracture, but I have appointment on the 19th at the (Expert government hospital) and they will do another X-ray to check on it. Because that

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S9999	Continued From page 2 leg hurts a lot more now. The housekeeper should not be lifting my leg and hit it on the chair or whatever. That has not happened before. R1's face sheet documented that R1 was last admitted 12/15/2021 with diagnosis that includes but not limited to Other lack of coordination, Type 2 diabetes Mellitus with foot ulcer, Dysphagia Oral phase, Venous insufficiency, (Chronic) (Peripheral), Edema unspecified Pain left wrist, Morbid (Severe) Obesity, Essential Hypertension, Bilateral Primary Osteoarthritis and gout. R1's assessment tool used in assessing facility residents MDS (Minimum Data Set) dated March 20, 2023, coded R1 has having a BIMS (Brief Interview for Mental Status) of 13 out of 15. Section G for ADL's (Activities of Daily Living Assistance) coded 3/3 showing that R1 needs extensive assistance with ADL self-performance and two plus personal physical assistance for ADL support. And section G G0400 coded R1 2 (Two) has impaired on the lower extremity. R1's radiology report for right ankle and foot x-ray dated 03/31/2023 documented under findings that "Examination reveals mild soft tissue swelling with some dorsiflexion of the toes and some demineralization and degenerative arthritis changes with no evidence of recent fracture or dislocation. Clinical correlation if symptoms should persist a follow-up AP view of the foot is suggested". R1's medical record progress notes late entry dated 3/30/2023 and timed 11:36 (11:36am) under General Progress Note, V2 DON (Director of Nurse's) documented in part that after transferring from (lift device) to bed, resident complaining his toe is bleeding. There were 2 CNA's present during transfer and neither saw resident injure his foot and didn't hear him express that he had hit his foot until after (R1) noticed his toe bleeding once he was in the bed.	S9999		

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S9999	Continued From page 3 Housekeeper also present in the room at the time of transfer and confirmed he didn't witness an injury. (RN), notified and toe assessed. On 04/11/23 at 11:05am, interview conducted with V7 (Housekeeper) regarding assisting transferring R1 from the bed into the wheelchair. V7 stated that "I helped in putting (R1) into the wheelchair, the CNA (certified Nurse's Aide) pointing to VI2 (CNA) was using the (transfer device) and there was no other CNA there. So, I (V7) helped in carrying (R1) foot on the pillow and one of the pillows fell but I did not see (R1)'s leg hit anything with the leg. I was holding to (R1)'s foot. We put R1 in the wheelchair and the leg (referring to right toes) was bleeding. So, I (V7) went to get the nurse". When the surveyor asked V7 about training on transferring a resident, V7 stated that "We (referring to housekeeping staff) usually do room changes moving beds and the furniture's, but no one trained me (V7) in transferring the patients (physically residents). I was just helping because no one (referring to Nursing staff) to help. When asked about the risk and how it can affect the resident when transferring resident without proper training. V7 stated that "Yes, they can fall and break their bones". On 04/11/23 at 11:40am interview with V12 (CNA) (Certified Nurse's Aide) identified as being present and was assisting in transferring R1 stated in part that she (V12) and V13 were the CNAs assisting with R1's transfer and after being transfer into the chair (Electric wheelchair) all I (V12) know is that (R1) was screaming saying that (R1) was bleeding from (R1)'s toes on the right feet. It was actually another CNA (V13) with me who was operating the (Lifting/transfer device) and I was lifting the legs with a pillow	S9999		

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under (R1)'s feet. Because R1 was conscious of (R1) legs. My hands started hurting, so I (V12) asked another staff to help. I needed help from any one around to help. (V7) identified as the house-keeping director was around so V7 helped in transferring R1. He (V7) came and grab the pillow (for R1's feet). V7 stepped back and got R1 into the chair and after the transfer I (V12) saw blood coming out of R1's feet, I (V12) grab the towel and wrap it and (R1)'s feet with it and called V17 (Wound Care Nurse). When the surveyor asked whether it was appropriate for housekeeping staff to assist in patient physical transfer, V12 stated that "No, it is not appropriate for house-keeping staff to assist in physically transferring residents". Then the surveyor asked why it is not appropriate. V12 stated that "I (V12) believed they are not trained to do so. They do not have proper training in how to transfer a resident and might not know the resident well and what they like".

On 04/11/23 at 11:19am interview conducted with V10 LPN (Licensed Practical Nurse) When the surveyor asked whether it was appropriate for housekeeping staff to assist in transferring a resident, V10 stated I (V10) was on duty that day when V7 helped to transfer R1, but I (V10) was not the Nurse an agency Nurse was on duty, but I (10) cannot remember the name (referring to V15's name). V10 then stated that "Never ask a house-keeper to help in transferring a resident or in lifting them (resident) into bed or a chair, they are not trained on how to do that and can cause resident to fall with any injury. And we are to prevent resident from falls or injury".

On 04/11/23 at 11:58am interview conducted with V13 (CNA) identified as the second (CNA) present and assisting with R1's transfer on

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03/30/23. When the surveyor asked what happened, V13 stated in part that I (V13) really don't have R1 every day, but when R1 was on the 3rd floor I have worked with R1. I have only worked here (referring to the facility) for only three weeks. We (referring to facility staff) were transferring R1 from the bed to the chair with (Lifting / transferring Device). It was my self and two other staff. V13 identified (V7) manager of housekeeping and V12 another CNA (Certified Nurse's Aide). We did the transfer and when we were done with R1, we noticed that R1 was bleeding from the right toe and R1 started screaming and yelling that we have injured (R1). I don't know what happened to R1's feet. (V7) was helping in carrying (R1)'s feet and I was working on the (Lifting/transfer Device). I don't know how (R1) started bleeding on the right feet toes, R1 just started bleeding everywhere. We called the Nurse, and they came to look at R1. V12 brought a towel to rap R1's feet.
R1's electronic medical records reviewed showed R15's RN (registered Nurse) documentation on 03/30/23 at 12:56 (12:56pm) that R1 requested Norco for pain 9/10 (Referring to the scale pain of 1-10) on the Right foot. V15 documented that Norco tablet 5-325 MG (Milligram) with instruction to give one (1) tablet by mouth every 12 hours as needed for pain for pain level over 6 (Six) or more was administered.

On 04/11/23 at 1:24pm V2 presented the facility internal investigation report dated 03/31/2023 that documented that this was written after interviews conducted with V7, V12 and V13 that V12 and V13 were operating the (Lifting Device) and V7 was holding pillows for resident's foot (referring to R1) at the time of transfer. R1 was transferred without incident and upon settling into the bed, noticed blood on (R1) toe. R1 began, yelling,

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saying V7 had injured (R1)'s toe. V7 statement presented dated 03/30/23 showed documentation signed by V7 documenting in part when the CNA was maneuvering the (lifting device) to put R1 into wheelchair there was no other CNA was available, so I (V7) assisted with holding resident (R1) foot with two pillows, one pillow fell to the floor, but resident (R1) foot remained on the other pillow during transfer, resident foot did not make contact with any other surfaces.
The facility concluded that proper staff was utilizing (lifting Device) with proper precaution. Resident (R1) did recognize blood on (R1) toe but there was no evidence injury occurred because of improper transfer. Blood was likely because of preexisting condition related to diabetic ulcer or circulation issues.
On 04/11/23 at 2:44pm, during interview conducted with V3 ADON (Assistant Director of Nurse's) regarding facility policy on fall risk and prevention regarding house-keeping staff assisting physically with transferring of a resident, and whether it is appropriate. V3 stated that "they (House-keeping staff) should not assist in actual resident transfer; it will be inappropriate because they are not trained. They can lift furniture's but not residents. There should be no hands-on care on the residents, for fall prevention and risk like resident sustaining an injury. We (referring to both V2 and self (V3) discussed with V7 about that".
On 04/13/23 at 10:21 am interview conducted with V16 NP (Nurse Practitioner) regarding R1's injury. V16 stated that she (V16) was not informed about R1's injury bleeding on the foot and when asked about whether it is appropriate for house-keeping staff to assist in transferring resident from bed will chair or from chair to the bed. V16 stated that "You know what I don't know their job description so I can't help you with that

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(referring to the surveyor question)". Then the surveyor asked V16 about ordering for X-ray R1 injured foot. V16 stated that "I (V16) did. I have my notes in there (referring to the computer)". When asked whether it was normal for R1 to be bleeding from the foot toes, V16 stated that "I am not aware that R1 was bleeding, so I don't know how to answer that question. The surveyor asked V16 about the general health status of R1, V16 stated that "I (V16) just saw (referring to assessing R1) very recently because (R1) was a V. A. (Specialty Hospital) patient and our company does not want us to see a V.A patient for complaint of foot pain. R1 reported right foot pain, from bumping his foot. R1 hit right foot on the wheelchair. And I (V16) ordered X-ray".
On 04/13/23 at 12:02pm, surveyor showed V3 the facility investigation report presented with signed statements from (V7). After reading the documents, V3 stated that "this is a Problem."

The facility policy titled Housekeeper Job description with no date documented that "the housekeeper is responsible to keep the facility clean, safe in accordance with current federal and state standards and comfortable manner.
The facility policy on Safe Lifting and Movement of resident with no date documented in part under policy statement that to protect the safety and well-being of staff and residents and promote quality care. The listed interpretation and implementation include resident safety, comfort and medical condition will be incorporated into goals and decisions regarding safe lifting and moving of the resident. Staff responsible for direct care will be trained in the use and mechanical lifting devices. Only staff with documented training on the safe use and care of the machines and equipment used in this facility will be allowed to lift or move the resident.

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S9999	Continued From page 8 The facility Lift, Transfer Policy presented and dated 2/28/22 documented in part that all resident care will be provided in safe, appropriate, and timely manner in accordance with the individual resident care plan. The facility policy titled Accidents and Incidents-investigation and Reporting with no date presented documented under policy and implementation listed procedure that includes but not limited to incident /accident report will review by the safety committee for trends related to accident or safety hazards in the facility and to analyses any individual resident vulnerabilities The facility policy titled Fall Risk assessment documented policy statement pointed out in part that resident risk factors for falls will establish a resident -centered falls prevention plan based on relevant assessment information. (B)	S9999		