STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010136	A. BUILDING: _____ B. WING _____	C 03/03/2023

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CROSSROADS CARE CTR WOODSTOCK	309 MCHENRY AVENUE WOODSTOCK, IL 60098

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S 000	Initial Comments Facility Report Incident of 2/4/23/IL156840 - Past-Noncompliance cited	S 000		
S9999	Final Observations Past Noncompliance, no revisit needed. 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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 were not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure a dependent resident was transferred safely with a total lift machine for 1 of 3 residents (R2) reviewed for safety in the sample of 11. This resulted in a strap of the full body sling, snapping and R2 falling to the floor and experiencing a pelvic fracture. This Past Non-Compliance lasted from February 4, 2023, to February 9, 2023. The findings include: The facility's Incident Report Form dated 2/5/23 showed R2 experienced a fall with a fracture on 2/4/23 at 10:30 AM. This report showed R2 was alert and oriented and can express her needs. R2 had an acquired left leg amputation and is non-ambulatory, requiring the use of a mechanical lift for transfers. On 2/4/23 at approximately 10:30 AM, 2 CNA's (later identified as V5 and V8) were transferring R2 from her bed to her motorized wheelchair. R2 was lifted above	S9999		

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S9999	Continued From page 2 the bed and began to turn the lift towards the motorized wheelchair. At that time, the strap under her right leg ripped causing her to fall to the floor, landing on her buttocks. R2 was complaining of pain in her lower back and left knee area. R2 went to the emergency room and returned to the facility with a diagnosis of a pelvic fracture. R2's Facesheet dated 3/1/23 showed she had diagnoses to include, but not limited to: left-sided hemiplegia and hemiparesis; morbid obesity; contracture of left arm; epilepsy; diabetes; hyperlipidemia; depressive episodes; anxiety; high blood pressure; coronary artery disease; COPD (chronic obstructive pulmonary disease); stroke; and left below the knee amputation. R2's facility assessment dated 1/17/23 showed R2 was cognitively intact; had no behaviors of rejection of care; and was totally dependent on two staff members for transfers. R2's Health Status Note dated 2/4/23 at 10:32 AM showed, "CNA reported to the nurse resident fell during transfer via (mechanical) lift. Per two CNAs, the sling snapped during the transfer. Resident slid off from the full lift sling feet first and fell on her buttock per the CNA. Resident denied hitting her head. Assessment conducted and completed. V/S (Vital signs) BP 171/85, HR 85, RR 20, T 97.9, Sp02 96% on room air..." The writer called V29 (Nurse Practitioner), R2's POA, and 911. R2 was transferred to the emergency room. R2's Nurses Note dated 2/5/23 at 6:36 AM showed R2 complained to the CNAs, during cares, that she had pelvic pain with turning. R2 was given Tylenol 650 mg.	S9999		

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S9999	Continued From page 3 R2's Nurses Note dated 2/5/23 at 2:15 PM showed R2 remained in bed this shift and requested Tramadol for pain in her "tailbone." R2's Provider Note dated 2/6/23 at 5:16 PM showed R2 was being transferred with the mechanical lift on 2/4/23, the lift strap broke, and she fell on the floor. R2 complained of left knee and hip pain and was sent to the emergency room. The CT scan of the chest, abdomen, and pelvis showed a fracture of the left pubic ramus. R2 reports pain in her left lower back/hip, which exacerbates with movement/turning to left and rates 9/10 (1-10, 10 is worst pain felt) with movement. R2 takes Tramadol (opiate pain medication) and Tylenol for pain control. R2 reports that she is in pain, even after taking Tramadol. This document showed, "...Assessment/Plan: fall with fracture of left pubic ramus on 2/4/23. Had long conversation with patient's daughter/POA. She agrees to start the following pain management: Norco 5-325 mg... Give 1 tablet by mouth at bedtime for severe pain, post fall for 7 days. Robaxin (muscle relaxant) 750 mg three times a day for low back pain for 7 days..." R2's Care Plan revised 9/29/21 showed R2 had impaired transfer skills. R2's Care Plan revised 2/6/23 showed R2 had pain related to pelvic fracture. R2's pain was aggravated by movement. On 3/2/23 at 9:54 AM, R2 was lying on her in bed and said she was staying in bed until around 12:30 PM. R2 stated, "I have pain everywhere, but it's worse on my left side because they dropped me from that lift. It was awful and scary.	S9999		

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S9999	Continued From page 4	S9999		

V8 and V5 (CNAs) were the ones helping me. They were getting me out of bed to my chair. The sling was old, ratty, and faded. Now they have all new ones since I fell. My chair was down the end of my bed. They put the sling under me and lifted me off the bed. Then they started to move the me over towards the chair, then I was on the floor. I'm not even sure what happened. It happened so fast and I screamed. I landed on my left stump area first, then my butt. I had pain right away. I'm not sure what the CNAs did after that. I was in shock. The male nurse came in and wanted the CNAs to get me back to bed, but they refused. They said that they couldn't move me. Then the ambulance came to get me and I went to the hospital. I stayed on the floor until the ambulance came. The hospital did a bunch of tests and said that I cracked my pelvis. I never heard of that before. It hurt so bad and there isn't much they can do for it. I just have to let it heal on it's own and take pain medication. I don't think that's fair. My roommate (R7) saw it happen. I don't know about R8. I have sharp pain at a "7" most of the time. The muscle relaxant seems to help the most. Now I guess, the slings are assigned to us. It wasn't like that before I fell."

On 3/1/23 at 10:31 AM, V8 (CNA) said she and V8 (CNA) were getting R2 up for the day. They used the mechanical lift to get R2 out of bed and everything seemed okay. V8 stated, "I was controlling the lift and V5 (CNA) was down by the chair. We lifted R2 off the bed and started to turn toward the chair. It all happened so fast after that. The strap by her right leg ripped. It was scary. The sling had fuzzies on it from the dryer. She fell immediately and hit her butt. I don't remember what R2 was saying because of what happened. I've never had that happen to me before. V5 (CNA) notified V6 (Agency RN) and he came and

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S9999	Continued From page 5	S9999		

checked her. She went to the hospital and came back later that day. She was being cooperative with the transfer and we did everything we should have; the sling just broke."

On 3/1/23 at 10:43 AM, V5 (CNA) said he and V8 were transferring R2 with the mechanical lift. We had R2 lifted of the bed and were turning toward the chair when the strap (bottom strap by her right leg) snapped in the middle. V5 stated, "I was surprised it snapped. As soon as all her weight was in the sling and the momentum of turning toward the chair. I assume the momentum of the movement is what made the strap snap. It snapped right tin the center of the loop. I've never seen that happen before. Once it snapped, she fell and landed on her butt, in a seated position. V8 (CNA) stayed with R2 and I went to notify the nurse (V6). She said she was in pain, scared, and wanted to go to the hospital. The ambulance picked her up and she seemed better when she came back (to the facility).

On 3/1/23 at 11:42 AM, V6 (Agency RN) said the V5 (CNA) told him that he and V8 (CNA) were transferring R2 with the mechanical lift, the strap broke, and she fell to the ground. V6 stated, "I went into the room immediately and did an assessment. She seemed to be in quite a bit of pain so I called 911 right away." V6 said R2 was in a seated position, on the floor. R2 had a left below the knee amputation, but that's the side she hit on the ground. She was crying. Her roommate saw everything and stated, "One minute she was in the lift. Then next minute she wasn't." V6 stated, "The CNAs showed me the sling. It snapped on the right side, by where R2's legs/feet would be. She came back from the hospital and I gave her some Tramadol for the pain. R2 had a fracture from the fall. I haven't

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S9999	Continued From page 6 seen a sling snap like that." On 3/1/23 at 9:41 AM, V1 (Nurse Consultant/Assistant Administrator) stated, "The loops of the slings can pick up lint. It can be hard to tell if the sling just had lint on it or if it was frayed. If they don't remove the lint to inspect the sling, then it could impede the inspection. We decided to stop drying the slings and purchased a large drying rack." On 3/1/23 at 1:28 PM, R4 said he hates the mechanical lift. R4 stated, "The first time I was in that thing it hurt my neck and the second time it hurt my back. It felt like it just dropped me down on the bed. Those old slings looked awful. I wouldn't be surprised (if one broke)." On 3/1/23 at 1:44 PM, R5 was sitting up in a custom wheelchair, using his laptop. R5 had a new full body lift sling underneath him. R5 stated, "They just got new slings a couple weeks ago and it's better now. I was concerned with the other ones. They looked frayed and worn on the straps. They got rid of all those old ones. The slings have various straps to adjust the angle of the lift and I always told them not to use the green strap on me. I told them to use a different one because you could tell the green one wasn't good." On 3/1/23 at 2:23 PM, R7 (R2's roommate) said she saw the whole thing. R7 stated, "I saw R2 in the lift, then she fell real fast. I heard all the commotion too. I heard, "Oh s***! Oh s***!" I'm didn't see the strap break, but I heard the commotion. R2 was crying and in pain. She went to the hospital and came back." On 3/2/23 at 10:11 AM, V13 (Laundry) entered the laundry room where there were 2 large	S9999		

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S9999	Continued From page 7	S9999		

washers and dryers. There were hooks by the door, with lift slings drying. The surveyor asked V13 what the dryer temperature is. V13 replied, "I'm not sure, but V14 (Laundry) will know." V14 walked into the room and stated, "Both dryers are set at 190 degrees (Fahrenheit)." V14 stated, "We were hang drying the slings for a while, but the hooks kept coming out. So, I would put them in the dryer until they were just damp, then remove the slings. Both dryers reach 190 degrees. Now we aren't drying the slings at all. V13 put some new hooks up and we hang dry all the slings. When we were drying the slings, they would collect lint all over them, especially on the straps. And we were not removing the lint. I guess it interfered with the sling inspections." V14 indicated that the washer and dryer nearest the doorway were used to launder the slings. The surveyor asked V14 if they write down their sling inspections. V14 walked across the hall, to the folding room and stood in front of bulletin board. V14 looked at the bulletin board and stated, "I used to have a form that I would complete with my inspections, but I haven't been writing them down lately." V14 said the facility replaced all their slings a couple weeks ago. V14 stated, "I can't remember the last time we ordered new slings before this batch arrived (in mid-February)."

On 3/2/23 at 10:48 AM, V15 (CNA Supervisor) said the CNAs should inspect the sling before each use to ensure resident safety and make sure the equipment is working properly. V15 said prior to R2's fall from the lift (2/4/23), the CNAs were supposed to inspect the slings with each use and laundry inspected the slings when they laundered them. V15 stated, "I don't know if there were any other inspections completed. I'm not even sure how many slings we had. We did order new slings. Now, I'm checking the new slings

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S9999	Continued From page 8	S9999		

weekly. I complete an audit tool and write the date the sling was "initiated," meaning the day the sling was put into service. I'm not sure when the old slings were put into service. (The surveyor showed V15 the monthly audit tools and the date initiated was blank for November and December 2022 and January 2023.) I wouldn't know when the sling went into service by looking at these audit tools. The new forms include more information because the manufacturer of the slings suggested slings be replaced after 6 months of normal wear and tear."

On 3/2/23 at 12:16 PM, V20 (Case Manager for Sling Manufacturer) said the facility should follow the deterioration log for proper laundering and inspection of the slings. V20 said the slings can deteriorate by the way the facility launders the sling; if any harsh chemicals are utilized to clean the slings; and if they are not washed on the gently cycle. V20 said the full body sling is made of plastic fibers and the high heat can problematic. The high heat will break down the fibers. V20 said with normal wear and tear at a facility, the sling will likely lose integrity after 6 months of normal wear and tear.

On 3/2/23 at 2:50 PM, V29 (Nurse Practitioner) said she was called by V6 (Agency RN) on 2/4/23 and notified that R2 had fallen from the lift and was in pain. V6 told me that R2 wanted to go to the hospital. V29 said she gave the orders to send R2 to the hospital for evaluation. R2 returned later that day and the emergency room diagnosed a pubic ramus fracture (pelvic fracture). V29 stated, "I don't remember if V6 told me the sling broke. I became aware of the sling breaking when I rounded at the facility on Monday. V29 said R2's fracture must heal naturally and the facility will do their best to

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S9999	Continued From page 9	S9999		

control her pain. V29 said falling from the lift, approximately 3-4 feet caused R2's pelvic fracture.

On 3/2/23 at 3:05 PM, V2 (Director of Nursing - DON) said she was not working when R2 fell, but she was notified that R2's lift sling had snapped. V2 said the staff reported that R2 was in the full body sling and had been lifted from the bed. V5 and V8 (CNAs) were starting to turn R2 toward the chair when the strap snapped and R2 fell 3-4 feet to the floor and landed on her buttocks. R2 was sent to the emergency room and came back later that day with a diagnosis of a pelvic fracture. V2 stated, "V22 (Dietary Manager) was the MOD (Manager On Duty) on 2/4/23. V22 removed R2's sling from circulation and inspected the other slings. On Monday I saw R2's sling and the strap had snapped right in the center. It split right where the weight would have been the greatest on the strap."

The facility's Monthly Sling Inspection Logs dated 11/16/22, 12/16/22 and 1/13/23 showed slings numbered 1-18. The "Date Initiated:" was blank on all three forms. The updated Monthly Sling Inspection Logs dated 2/17/23 and 2/24/23 showed that 9 slings were inspected and were put into circulation on 2/10/23. The facility's Monthly Sling Inspection Log dated 2/21/23 and 2/28/23 showed 20 new were assigned directly to residents and put into circulation on 2/14/23.

The surveyor requested a Mechanical Lift Policy. The facility reported they follow the manufacturer's recommendations and instructions for safe lift transfers.

The undated Sling Manufacturer's Guideline for Identifying Deteriorated Slings showed,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 10 "Accelerated Deterioration from Bleach, High Temperature Wash or Drying. Slings, especially the loop straps that have been damaged from being laundered in unsuitable conditions (bleach, high heat wash or dry) may appear to be in good condition but the actual tensile strength of the material may be compromised an pose a safety risk and should not be sued for lifting a patient or resident... (The Manufacturer) slings have been designed and tested for laundry wash conditions of 170 degrees Fahrenheit and air dry or dry at low temperatures... Care instructions in the sling label should always be followed... Causes of Deterioration Due to Laundry Conditions: ...2. Temperature or high heat damage. This can occur if slings are left in the dryer for too long or dried at excessive heat. The slings are made from plastic fibers and do not absorb as much water and require less drying time than other laundry of natural fiber and fabric. 3. Mechanical/Wash Action can contribute to the accelerated deterioration of the slings, especially if they have been subjected to the above conditions. Slings should be washed using a gentle cycle to minimize excessive agitation and internal fiber abrasion." The undated Sling Manufacturer's Full Body Sling Instructions Manual showed, "...Carefully inspect the sling before each use for wear and damage to seams, fabric, straps, and strap loops. Torn, cut, frayed or broken slings can fail, resulting in serious bodily injury to the user. Use only slings that are in good condition. Discard and destroy old, unusable slings... Washing instructions: 1. Machine wash warm or cold. a. Maximum washing temperature 185 degrees F. b. Wash at 160 degrees F for 3 minutes. c. Wash at 145 degrees F for 10 minutes. d. Air dry or tumble dry at cool or very low temperature... After each	S9999		

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S9999	Continued From page 11 laundering (in accordance with the instructions on the sling), inspect sling(s) for wear, tears, and loose stitching. Bleached, torn, cut, frayed, or broken slings are unsafe and could result in injury. Discard immediately... Useful life of this product is six months from date of purchase under normal use, heavy or excessive washing may reduce useful life of the product..." Prior to the survey date of 3/1/23, the facility took the following actions to correct the non-compliance. 1. Inspect each Hoyer sling for torn/worn/frayed or unstable material. Completed 2/4/23. 2. Review laundering process for issues. Completed 2/4/23. 3. Install area away from vents for Hoyer slings to air dry. Completed 2/7/23. 4. Educate laundry personnel on inspecting straps and removing lint that impedes inspection and air-drying slings. Completed 2/5/23. 5. Perform mechanical lift competencies of the 2 CNAs involved in event. Completed 2/5/23. 6. Conduct mechanical lift competencies for all remaining CNAs. Completed 2/5/23. 7. Review manufacturer's guidelines to ensure all components are met. Completed 2/5/23. 8. Review Monthly sling audits for compliance. Completed 2/5/23. 9. Interview CNAs to identify any issues they have encountered. Completed 2/5/23. 10. Conduct RCA (Root Cause Analysis) to identify issue/corrective action or enhancements to system. Completed 2/4/23. 11. Impromptu QAPI meeting for input and review. Medical Director involved and reviewed RCA and approves plan. Completed 2/4/23. 15. All slings were replaced. Completed 2/9/23. (A)	S9999		