STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001119	A. BUILDING: _____ B. WING _____	C 01/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELEVATE CARE RIVERWOODS	3705 DEERFIELD ROAD RIVERWOODS, IL 60015

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S 000	Initial Comments FRI of 1/10/2024\IL168908	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 that each resident receives adequate supervision and assistance to prevent accidents.	S9999		

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These Requirements were NOT MET as evidenced by:

Based on interview and record review the facility failed to ensure a resident was safely transferred, via a mechanical lift, in a manner to prevent resident injury. This failure resulted in R1 fracturing her right clavicle(collarbone) and right lower leg (tibia and fibia), after falling out of a mechanical lift, due to the cloth sling of the mechanical lift becoming unhooked from the lift. This failure applies to 1 of 3 residents (R1) reviewed for safety and supervision in the sample of 3.

The findings include:

The facility's Fall Incident report dated 1/10/24 showed staff (V4 Registered Nurse/RN and V5 Certified Nursing Assistant/CNA) were transferring R1 from her bed to wheelchair, via a mechanical lift, when R1 moved her upper body in the lift sling which caused "the sling to unhook from the lift." R1 then fell out of the lift, onto to the floor. 911 was called. R1 was transferred by ambulance to a local hospital. V10 (Family of R1) was in R1's room and witnessed R1's fall. The report showed prior to the transfer, R1 and V10 were "speaking loudly" back and forth to each other, in their native language, as R1 was initially refusing to get out of bed and was refusing cares offered by staff. The report also showed facility staff "had to remind (R1) more than once to keep her arms crossed over her chest and to sit still" while attempting to transfer R1.
R1's hospital records dated 1/10/24 showed, "Patient was being transferred by [mechanical] lift at nursing home and fell... Patient complains of right leg pain and right shoulder pain..." The

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records showed R1 was diagnosed with a right clavicle (collarbone) fracture and a right tibia/fibia (lower leg) fracture as a result of the fall.

R1's current care plan showed R1 had a history of behaviors including moderate to extreme anxiety, refusing cares, depression, agitation, impulsive behaviors, verbal behaviors, and physical behaviors. The care plan showed, "Utilize de-escalation strategies when a resident has an episode of agitation/anxiety behaviors... allow time alone to promote calmness...Evaluate the potential causal factors contributing to feelings of anxiety. Work with the resident to eliminate causes whenever possible." A care plan focus area for R1, initiated 7/23/23, showed R1 required the use of a [mechanical] lift for transfers related to her diagnoses of anxiety, weakness, and a previous fall resulting in a right femur fracture. The care plan focus area showed R1 had a history of "moving during [mechanical] lift transfers." The plan showed, "Hook sling loops on metal hooks and pull sling down to ensure security... Prompt resident prior to lifting to ensure readiness..."

On 1/22/24 at 11:47 AM, R1 was in bed. Purple bruising was noted above R1's right eye and down R1's right lower leg. This surveyor tried to interview R1, twice, but was unsuccessful. Although awake, R1 would only shrug her shoulders and gave no verbal response when questioned.

On 1/22/24 at 10:20 AM, V5 CNA stated on 1/10/24, R1 and V10 (Family of R1) "were arguing and yelling at each other because (R1) was refusing to get out of bed and go to her appointment. (R1's) face was red. She was mad." V5 stated R1 eventually agreed to get out

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of bed and go to her appointment but continued to argue with V10. V5 stated, "We (V10 and V4 RN) continued to get (R1) ready. We got her up into the lift. She was still arguing with (V10). When (R1) leaned to her left to shake her left hand at (V10), the lift sling dipped down and the sling loop, by her left leg, came away from the lift. (R1) rolled out of the lift onto the floor. I don't know how that happened." V10 stated for resident safety, staff are not to transfer a resident via mechanical lift if the resident is agitated. V10 stated, "(R1's) family gets her worked up a lot. Next time, we will ask her family of leave the room so she can calm down."

On 1/22/24 at 10:32 AM, V4 RN stated on 1/10/24, V10 (Family of R1) was "shouting" at R1 and R1 "was yelling back at (V10) because (R1) initially did not want to go to her appointment. (R1) was all worked up. We continued to work on getting (R1) up. We got her up off the bed, in the sling. She was still arguing with her family. She kept moving while in the sling. We told her to cross her legs and arms (during the transfer) but she wouldn't listen to us. As (R1) raised her arm at (V10) and was screaming, it caused her weight to shift in the sling. The sling dipped down and came unhooked from the lift. (R1) fell on the ground. It happened so fast..." V4 stated, "We shouldn't have transferred her when she was all worked up. We should have removed her family and given her time to calm down."

On 1/22/24 at 10:50 AM, V10 Family of R1 stated on 1/10/24, R1 was agitated prior to the transfer because, "She was not ready for the doctor's appointment when I got there. She was confused and is very hard of hearing. She was not sure what doctor she was going to see..." V10 stated, "The sling part came away from the lift. (R1)

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S9999	Continued From page 4 tumbled out of the lift, head first, onto the floor... On 1/22/24 at 11:15 AM, V3 Nurse Practitioner (NP) stated R1 was hard of hearing and had periods of confusion. V3 stated, "(R1) has anxiety. She can get agitated and refuse cares. Within the past year, she fell and broke her right femur (upper leg). She was hospitalized where she underwent surgery to repair her femur. While hospitalized , staff dislocated her previously repaired femur fracture, during a transfer. She had to go back to surgery again. By the time she got admitted to the facility, she was so scared of being hurt when transferred or during cares, she was in a full-on panic disorder. She was refusing all cares. I had to put her on medications initially to help treat her panic disorder. If (R1) gets worked up, agitated, refuses cares, or is not cooperative, staff should come up with a plan to mitigate her safety concerns. Hold off on transferring her. Let her express her concerns, then try to reapproach her. If she won't follow staff instructions such as holding still during a transfer, don't transfer her. Give her time and reapproach. If she is having behaviors and has an appointment she must go to, slide her from her bed to a gurney, to make sure she is transferred safely." On 1/22/24 at 8:54 AM, this surveyor and V9 Maintenance Director examined the mechanical lift and cloth sling used to transfer R1 on 1/10/24. No defective areas and/or missing parts were noted on the lift. No weakened areas or holes were noted on the cloth sling. V9 stated there was "no way the sling just comes away from the machine if the loops are secured in place and two staff are doing the transfer." V9 stated when residents are being transferred via mechanical lift, the resident should be "calm" to prevent any	S9999		

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S9999	Continued From page 5 resident injury. On 1/22/24 at 9:50 AM, V8 (Representative of the company that manufactures the mechanical lift used to transfer R1) stated, "We leave it up to the discretion of the facility but we recommend that a resident is in a calm state when transferring them in a lift." V8 stated if the resident can't be still and calm, then we don't recommend transferring them to ensure they aren't injured while being transferred. (A)	S9999		