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	IL6000772	A. BUILDING: _____ B. WING _____	C 04/02/2025

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BEACON HILL	2400 SOUTH FINLEY ROAD LOMBARD, IL 60148

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S 000	Initial Comments Complaint Investigation 2572672/IL189007	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b)5) 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 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	S9999		

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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. (Section 3-202.2a of the Act)

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. Restorative measures shall include, at a minimum, the following procedures:

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

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.

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These regulations were not met as evidenced by:

Based on observation, interview and record review, the facility failed to safely transfer a resident (R1) who required maximum assistance. The facility also failed to assess, identify, and provide specific and consistent interventions to ensure safety during a transfer. This failure resulted in R1 sustaining a left leg laceration requiring 29 staples at the hospital.

This applies to 1 of 3 residents (R1) reviewed for safe transfer and accidents.

The findings include:

The EMR (Electronic Medical Record) shows that R1, an 81-year-old with diagnoses that includes encephalopathy, muscle weakness, congestive heart failure, morbid obesity, atherosclerosis heart disease, coronary artery disease and Crohn's disease. R1 was admitted to the facility on February 13, 2025. Prior to R1's admission to the facility, R1 was hospitalized for 20 days due to bowel obstruction and had undergone bowel resection with ileostomy on February 5, 2025. R1 was again sent to the hospital on February 18, 2025 for urinary tract infection, was admitted and returned to the facility on February 24, 2025.

The MDS (Minimum Data Set) assessment dated March 2, 2025 showed that R1's cognition was moderately impaired with BIMS (Brief Interview Mental Status) score of 11/15. The MDS documents that R1 was dependent on staff for toileting, shower and hygiene and required "substantial/maximum assistance for transfer from chair to bed and bed to wheelchair."

The CNA (Certified Nurse Assistant)

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documentation tasks for a period of 8 days from March 18 through 25 of 2025 showed that R1 was identified as requiring more of total dependence from staff than of an extensive assistance. R1 had 10 episodes of totally dependent from staff and 8 episodes of extensive assistance.

On March 31,2025 at 10:00 A.M., V10 (CNA/ Restorative Aide) stated that R1 uses the mechanical total lift transfer device even before the incident. V10 said she was referring to the bruise sustained by R1 on March 24, 2025 and a laceration with 29 staples that was sustained by R1 on March 25, 2025.

On March 31,2025 at 1:18 P.M., V6 (RN/Registered Nurse who was regularly assigned to R1 during day shift) had stated that she started taking care of R1 the first week of February 2025. V6 also said that R1 had always used the mechanical transfer lift device since the first week of February during R1's transfers to bed from wheelchair and vice versa. V6 also said that she was assigned to R1 on March 25 and March 27, 2025 and that she had received report that R1 sustained a large bruise to the left lateral side of the mid leg on March 24, 2025 during the evening shift while being transferred from wheelchair to bed. V6 also said that she again received a report that R1 had sustained a large laceration to the same site (left lateral side of mid leg) during a manual transfer from (V7 and V8 - CNAs) on March 25, 2025. V6 said that R1 was sent to the hospital via 911 on March 25, 2025 due to the laceration. V6 also said that R1 required 29 staples to close the laceration.

On March 31, 2025 at 10:30 A.M., R1 was observed lying in her bed. R1 was visiting with

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both V16 (R1's POA/Power of Attorney/Family), and V17 (R1's Family). R1 was alert, coherent, oriented times 3 but forgetful. R1 said that that she sustained a bruise and a cut to her left lower leg after she was transferred from wheelchair to bed by V7 and V8. R1 said she was not sure if V7 and V8 had used the mechanical transfer lift device since there was no consistency when staff uses the lift device. During this time of observation, V17 said that she was present during R1's transfer from wheelchair to bed provided by V7 and V8 on March 24, 2025 at around 6:30 P.M. V17 said that upon transfer, R1 was placed by V7 and V8 to lying position. V7 pulled down R1's pants. V7 and V17 discovered R1's fresh bruise (dark purplish color) from below the knee down to the middle of the left lateral leg. V17 said that V7 and V8 had manually transferred R1 and transferred R1 again in the same manner on March 25, 2025. around 6:00 P.M. V17 said that a mechanical transfer lift device was not used during these transfers. V17 said she had asked about the use of the mechanical transfer lift device but was told different answers from staff regarding when to use the mechanical transfer lift device. V17 said that R1 must have hit the wheelchair locking mechanism device that holds the leg rest. The locking mechanism device was exposed when leg rests were removed for transfer. As observed, the mechanical locking device protrudes out around ½ or ¾ inch and were irregular metal edges that is possible to cause a bruise to R1's fragile skin. V17 also pointed that another environmental hazard that was next to R1 during transfer was the metal post from the bed rail of R1's left side of bed. V17 said that there was no cap cover, and the metal has a sharp edge which was exposed and potentially can cut R1's fragile skin when bumped during transfer. V17 added

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that the facility applied a metal cap covering to the metal post the morning of March 26, 2025 after R1 sustained a large laceration during transfer on March 25, 2025. This metal post would be on the same side to R1's left leg during transfer. The metal post of the bed rail was on R1's left side of her bed. It was also observed during this time that when V12 (Wound Nurse) opened R1's left leg bandage, it exposed R1's laceration on the left lateral leg. It has 29 staples that were intact. The wound has an irregular edge. There was purplish to light yellowish discoloration from below the left knee to the mid knee area. There were also 2 intact blisters on top of the bruised leg. V12 measured the laceration as 12 cm (centimeters) in length x 7 cm in width. The bruise as measured by V12 showed 4.4 cm in length and 2.3 cm in width.

On March 31, 2025 at 1:14 P.M., V9 (RN) said she took care of R1 during the day shift on March 24, 2025. V9 said that R1 was not identified with a bruise during the day shift.

On March 31, 2025 at 3:24 P.M., V5 (RN) said that R1 came back to the facility from a cardiac appointment clinic. V5 said that around 6:30 P.M., V7 and V8 had transferred R1 to bed from wheelchair. V5 said she was called regarding the fresh bruise identified immediately post transfer when R1 was placed lying in bed. V5 said that according to R1 it happened during the transfer. V5 said that she did not investigate further since she assumed the bruise occurred while R1 was in the cardiology clinic, but then R1 was not transferred from her wheelchair and was only checked on the upper torso during the cardiology appointment per V17 since she had accompanied R1 to the appointment.

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On March 31, 2025 at 9:06 A.M., V18 (R1's Family) said he was visiting R1 on March 25, 2025 during the evening time. V18 said that R1 had requested to be put back to bed and V7 and V8 came to transfer R1 around 6:30 P.M. V18 said he was asked to leave R1's room and he stayed outside R1's door. However, he noticed that V7 and V8 did not bring with them a transfer lift device to R1's room prior to R1's transfer. V18 said that he was surprised when he was told that R1 had sustained a laceration to the leg during transfer and that R1 needed to be sent out to the hospital via 911. V18 said R1 was bleeding, however, did not see the laceration since it was already wrapped with bandage. V18 said there were drops of blood on the carpeted floor on the left side next to R1's bed.

On March 31, 2025 at 3:30 P.M., V7 said she helped V8 transfer R1 from wheelchair to bed on March 24 and 25 around 6:30 P.M. V7 also said that R1 was transferred manually by both her and V8. V7 also said that they did not use the mechanical transfer lift device for both transfers. V7 added that the CNA task documentation showed that R1 was an extensive to total dependence from staff for transfer. V7 added that the task documentation did not show that a mechanical transfer lift device was to be used. V7 also said that during transfer, R1 was heavy, was a pivot transfer, and R1 was barely standing. V7 added that R1 was not standing straight, like a flexed torso position so it added a challenge for transferring R1. Upon transfer, and R1 was positioned in bed, R1 was identified with large dark purple bruise to the left lateral leg. V7 also added that R1 was discovered with large laceration to the left lateral mid leg immediately upon transfer on March 25, 2025. V7 said she noticed fresh oozed blood that has seeping

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through R1's pants. V7 said that upon removing R1's pants, R1's large laceration to he left lateral leg showed an irregular edge, was of the same site where the bruise was. V7 said she immediately called V4 (RN).

On March 31, 2025 at 3:45 P.M., V8 said she had helped V7 transfer R1 from wheelchair to bed on March 24 and 25 around 6:30 P.M. V8 also said that R1 was transferred manually by both her and V7. V8 said that they did not use the mechanical transfer lift device for both transfers. V8 added that the CNA task documentation showed that R1 was an extensive to total dependence from staff for transfer. V8 added that the task documentation did not show that a mechanical transfer lift device was to be used. V8 also said that during transfer, R1 was heavy, was a pivot transfer and R1 was barely standing. V8 added that R1 was not standing straight, like a flexed torso position so this makes "(R1) totally dependent from us during the transfer." Upon transfer, V8 explained that R1 was positioned in bed, with V8 holding up her upper torso and V7 holding the lower torso. V8 said they noticed seeping of fresh blood from R1's pants and a laceration to the left leg. V8 said that V7 called V4 to check on R1.

On March 31, 2025 at 2:14 P.M. V4 (RN) said she took care of R1 on March 25, 2025 during the evening shift. V4 said she was called by V7 on March 25, 2025 around 6:30-7:00 P.M. and was informed by V7 that R1 had sustained a laceration while being transferred to bed from wheelchair. V4 said she immediately went to check R1. V4 said that upon entering R1's room, R1 was in bed, and she noted a large laceration with an irregular triangle like shape edge surrounding the cut. V4 also said she noted

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traces of fresh drops of blood on the carpeted floor by the left of R1's bed and on the top edge of the metal post of the left side bed rail. V4 also noted that there was no plastic cap that covered the end of the metal post. V4 added that since R4 was manually transferred, R1's left leg must have hit the metal post that was also next to R1's left leg while standing for pivot transfer. V4 said that she called V13 (RN/Wound Care Nurse) to help so she can send R1 to the hospital via 911 due to the large laceration.

On March 31, 2025 at 5:30 P.M., V13 (RN/wound Nurse) said she looked at R1's large laceration. V13 added that she applied a bandage and pressure to the wound to control the bleeding.

The EMR showed no documentation that an assessment was made to identify correct device to use to ensure safe transfer of R1. There was no evaluation/assessment for the use of the mechanical transfer lift device.

The care plan dated February 14, 2025 showed "(R1) has an ADL (Activities of Daily Living) self-care performance deficit r/t (related to) fatigue, impaired balance s/p (status post) abdominal surgery d/t (due to) SBO (small bowel obstruction). Date Initiated: 02/14/2025 Revision on: 02/14/2025 o The resident will improve current level of function in ADLs through the review date. Date Initiated: 02/14/2025 ...o TOILET USE: The resident requires extensive assistance by (2) staff for toileting transfer, & one person for hygiene Date Initiated: 02/14/2025 Revision on: 03/26/2025 ...TRANSFER: The resident requires extensive assistance by (2) staff to move between surfaces, via Hoyer lift Date Initiated: 02/14/2025 Revision on: 03/26/2025."

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On March 31, 2025 at 4:10 P.M., V2 (RN/MDS/ Care Plan staff) stated that R1 was extensive to total assistance from staff for transfer. V2 added that "there was no assessment for the use of mechanical lift device, whether (R1) needs to use and it is up to nursing judgement when to use the mechanical transfer lift device."

On April 01, 2025 at 9:14 A.M., V19 (PT/Physical Therapist/Director of Skilled Rehabilitation) stated that R1 required extensive assistance for transfer under therapy treatment that was provided by the therapist. V19 also added that during therapy session, R1 demonstrated guarding her stomach, body torso was flexed like almost fetal position which makes it harder during task transfer. V19 also added that nursing department should have assessed R1 for safe transfer and should have identified as to when to use the mechanical transfer device to ensure safe transfer. V19 explained that during therapy treatment on the day shift, R1 might still have the energy to participate under skilled therapy. However, resident' energy changes especially in the afternoon when residents become weak and tired. During this time, a non-skilled caregiver provides care. V19 added this is more of a reason that an assessment by nursing should have been made to determine usage of mechanical transfer lift device and ensure safety with transfers.

The facility's undated policy for transfers documents:
"It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure, and comfortable experience for the resident while ensuring team members are safe in accordance with current

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S9999	Continued From page 10 standards and guidelines. Guidelines: ...7. Select the transfer method that meets each resident's individual mobility needs. 8. Utilize appropriate assistive device to assist with the transfer. 9. Use the same transfer techniques consistently to enhance learning and improve the resident's skill." (B)	S9999		