STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006605	A. BUILDING: _____ B. WING _____	C 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH AURORA LIVING & REHAB CTR	310 BANBURY ROAD NORTH AURORA, IL 60542

(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: 2573019/IL189621	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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S9999	Continued From page 1	S9999		

These Requirements were NOT MET as evidenced by:

Based on interview and record review the facility failed to safely transfer a resident (R1) with the use of a mechanical lift.

This failure resulted in the resident falling and sustaining fractures to the right hip, left pelvis, pubic bone, and lumbar vertebra.

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

The findings include:

R1's EMR (Electronic Medical Record) showed R1 was admitted to the facility on 8/28/2023 with multiple diagnoses including generalized edema, chronic pain, impaired mobility, and generalized weakness. R1's MDS (Minimum Data Sheets) dated 3/19/2025 shows R1 was dependent on staff for transfers and required the use of a mechanical lift.

On 4/07/2025 at 11:25 AM, V6 (Certified Nurse Assistant/CNA) was interviewed regarding R1's fall incident on 3/31/2025. V6 said she secured R1's sling to the mechanical lift to transfer him from the bed to his wheelchair. V6 said V4 (CNA) then came to the room and stood behind R1's wheelchair as she started to operate the lift. V6 said she started to maneuver the machine as V4 remained behind the wheelchair (not within close reach of R1). V6 said she then started to turn the machine when the sling's lower left strap suddenly ripped and R1 fell to the floor. V6 said R1's sling was worn out from overuse because it had not been replaced since R1's admission.

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On 4/07/2025 at 9:45 AM, V4 (CNA) said she was asked to assist V6 with R1's transfer on 3/31/2025. V4 said that when she arrived at R1's room V6 had already connected R1's sling to the lift. V4 said she positioned herself behind R1's wheelchair (not within close reach of R1) to receive him while V6 started to maneuver the machine. V4 said R1 fell as V6 started to turn the machine because the sling's lower left strap ripped. V4 said they were unable to respond quickly to reduce R1's fall impact from the mechanical lift.

On 4/07/2025 at 2:00 PM, V2 (Director of Nursing/DON) said she responded to R1's fall incident. V2 said R1 had to be transferred to the hospital because he was complaining of pain to his back, legs, and elbows. V2 said she interviewed V6 and V4 after the incident and assessed R1's sling. V2 said the sling's lower left and right straps were ripped completely in half. V2 said she had concluded that R1's fall was because the sling's straps were frayed causing them to rip during R1's transfer. V2 continued to say R1's sling appeared worn out from overuse. V2 said R1's sling should have been inspected before being used and tossed because it was unsafe for use. V2 also said she expects both staff members to be actively assisting with mechanical lift transfers to ensure safe transferring and be able aid in an emergency.

On 4/07/2025 at 3:00 PM, V12 (Nurse Practitioner/NP) said R1 required total assistance with mobility and transfers. V12 said R1 required the use of the mechanical lift for transfers and expected the staff to be trained on how to safely use the lifting equipment to ensure safe transfers. V12 also said the facility was expected to

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maintain operable lifting equipment based on policy or manufacturing guidelines to ensure residents were provided with safe equipment.

R1's Care Plan Activity Report with a review date of 1/03/2025, showed R1 was at risk for falls and required staff assistance with transfers. R1's transfer focus problem had multiple interventions, including "Assist with safe transfers as recommended: [Mechanical] lift and 2-person assist", "Provide equipment for transfers: [Mechanical] lift", and "Utilize mechanical lifts as appropriate."

R1's progress note dated 3/31/2025 shows "At about 1140, the writer was notified that the resident had a witnessed fall during transfer with a [Mechanical] life from bed to wheelchair ...Resident complained of pain 7/10 on his legs, back, and elbows ...911 was called and they arrived and took him out to [Hospital] ER."

R1's Accident Investigation Form dated 3/31/2025, shows R1's fall occurred because the "sling broke." The form said the sling should have been inspected before being used to transfer R1 on 3/31/2025.

R1's Fall Incident Final Report dated 4/04/2025 shows "During the [Mechanical] lift transfer, resident suddenly fell to the ground on his buttocks ...The CNA who navigated the resident stated that the fall happened so quickly that she didn't have time to reach to reduce the impact ...Upon further investigations, both bottom loops of the sling were fray apart."

R1's hospital notes dated 3/31/2025 shows R1 was "brought from nursing facility for evaluation of a fall. Reportedly the [Mechanical] lift broke and

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he was dropped on the ground. Patient reports pain in his neck, back, hip, and legs. Pain is constant, worse with movement. Images showed closed right acetabular fracture; Fracture of left ischium, Pubic bone fracture, Fracture of the transverse process of lumbar vertebra."

The facility's policy titled Hydraulic Lift dated 08/2024, shows "Purpose To enable two staff to lift and move a resident safely, with little effort as possible." The policy does not provide instructions on equipment checks before use, including slings.

The facility's policy titled Resident Supervision Policy dated 07/2024, shows "To ensure the facility provides an environment that is free from accident and hazards over which the facility has control and provide supervision and assistive devices to each resident to prevent avoidable accident."

The facility's provided [Mechanical] lift manufacture's document titled Manual/Electric Portable Patient Lift undated, said "Transferring to a Wheelchair... [Company] recommends that two assistants be used for all lifting preparations, transferring from and transferring to procedures ...Maintenance ...SLINGS AND HARDWARE CHECK ALL SLING ATTACHMENTS each time it is used to ensure proper connection and patient safety. Inspect sling material for wear. Inspect strap for wear."

(A)