STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006019	A. BUILDING: ______ B. WING ______	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDINA NURSING CENTER	402 SOUTH CENTER STREET DURAND, IL 61024

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S 000	Initial Comments Annual Certification Survey & FRI of 1/7/2024/IL170699	S 000		
S9999	Final Observations 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 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	S9999		

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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 interview and record review, the facility failed to perform a safe mechanical lift transfer for 1 of 3 residents (R12) reviewed for safety/supervison in the sample of 15 . This failure resulted in R12 experiencing a fall from the mechanical lift and sustaining a hematoma.

The findings include:

R12's electronic face sheet printed on 3/13/24 showed R12 has diagnoses including but not limited to Alzheimer's disease, dementia with behaviors, congestive heart failure, acute respiratory failure with hypoxia, acute pulmonary edema, major depressive disorder, and repeated falls.

R12's facility assessment dated 3/7/24 showed R12 has severe cognitive impairment and is dependent on staff for all transfers.

On 3/12/24 at 9:58AM, R12 was laying in her bed with a yellow, purple, black hematoma to her right

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forehead and eye.

R12's progress notes dated 3/7/24 showed, "Witnessed fall at 1400. Resident found on right side, legs over (mechanical lift) sling, (mechanical lift) sling with one strap not correctly fastened..CNA's (Certified Nursing Assistants) state that resident slid out while trying to rotate (mechanical lift) towards bed, resident slid out of sling. CNA's stated that it was so fast they are not sure if she hit but they did try to grab her and slow the fall ...hematoma developing to right front forehead."

R12's care plan dated 9/26/23 showed, "(R12) is at risk for falls, she no longer ambulates and has started using a (reclining wheelchair) for proper positioning. Her diagnoses includes: anxiety, depression, dementia with behaviors, Alzheimer's disease, and osteoarthritis. (R12) has a low bed which is left in the lowest position when she is left unattended while in bed, floor mat while in bed, and (mechanical lift) with assist of 2 with all transfers."

On 3/14/24 at 8:27AM, V6 (Certified Nursing Assistant) stated, "(V4-Certified Nursing Assistant) and I were transferring (R12) with the (mechanical lift) and we pushed the button to lift her up and she just fell out. I don't know exactly what happened because I hooked my side of the lift so (V4) must not have done her side. They have never done any previous competencies for me to watch me use the lifts."

On 3/14/24 at 9:40AM, V4 (Certified Nursing Assistant) stated, "The incident with (R12) happened very fast. We were transferring her from the reclining wheelchair to her bed and I remember there was a lump in her bed from the

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mattress. I hooked up the left top hook and I thought (V6) hooked up the other 3. When I was over at her bed I wasn't looking and was fixing her bed and (V6) started lifting her. It was both of our faults for not checking to ensure all of the straps were hooked. I had my back turned to (R12) and when I turned around she was falling out of the sling and landed on top of the base of the lift on her side. (V10-Restorative Nurse) told me she wanted to watch me do a (mechanical lift) transfer but she hasn't done that yet. I don't know when she is going to do my training."

On 3/14/24 at 10:31AM, V10 (Restorative Nurse) stated, "(R12) has been a (mechanical lift) transfer since I started here in January. There have never been any issues. I don't recall any competencies being done with staff for mechanical lift transfers that I know of. I reacted right away with the investigation. I checked (mechanical lift) policies and made sure everyone was re-educated on our policy. I looked at the (mechanical lift) checkoff and made sure I started training staff on the 8th (one day after it happened). Every day I go around and make sure I am getting the staff trained right away. I posted the (mechanical lift) policy at each nurse's station and have asked the staff that next time they do a (mechanical lift) transfer to let me know so that I can see the transfer. Once the resident's bottom comes off the surface, the transfer should be paused to make sure it's going to be a safe transfer. All I can do is try to re-educate them. I am trying to remind them that the black straps on the slings are not for using, they are for safety. I didn't know that so I learned that as well. They are there and should be hooked up as well so that if the colored straps fail, the black straps catch the sling. Both staff members should have their eyes on the resident so one can run the lift

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and the other one can ensure safety. I don't know if I even did (V4's) training yet. I haven't been doing anyone since you guys have been here since we have been busy. I still have to catch her to do it."

On 3/14/24 at 10:47AM, V2 (Director of Nursing) stated, "I would expect all straps on the (mechanical lift) to be hooked for safety. I would expect that both staff have eyes on the resident when doing a transfer to ensure the transfer occurs in a safe manner. Occasionally they may turn their back to fix something quick but they should know what's going on. (V10) has been re-educating CNA's and observing transfers to ensure the aides know how to perform the transfers. Both staff should have been trained immediately to prevent this from happening to anyone else. I'm not sure why they haven't been."

Employee in-service records from 2/204-3/14/24 showed no documentation of in-services on fall prevention/safe mechanical lift transfers.

Competencies for V4 and V6 were requested and not received.

The facilities nursing schedule for March 2024 showed V4 (CNA) worked 3/9/24 and 3/11/24 and V6 (CNA) worked 3/7/24, 3/8/24, 3/10/24, and 3/12/24 without receiving any training on safe mechanical lift transfers.

The facility's policy titled, "Mechanical Lift Policy/Procedure" dated 3/8/2024 showed, "(Mechanical lifts) are used to enable staff to safely transfer a resident from once surface to another. A minimum of two appropriate staff members is required...Attach the straps of the (mechanical lift) sling to the swivel bar, and check

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S9999	Continued From page 5 for proper placement prior to lifting the resident up off the bed....as one staff member manages the (mechanical lift) to raise the resident up, the second staff member provides support to the resident as needed, guiding legs to avoid injury, and guiding the resident to/from the bed to over the wheelchair, all while observing the resident for safety..." (B)	S9999		