Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **0050757**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **01/13/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF OLNEY	**410 EAST MACK , OLNEY, Illinois, 62450**

(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) COMPLETION DATE
S0000	Initial Comments Complaint investigation 25512530/2701245	S0000		01/13/2026
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)1)3)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 care needs of the resident.	S9999		01/15/2026

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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 safely transfer and reposition; and failed to promptly assess and treat a resident with severe pain for 1 of 10 Residents (R1) reviewed for pain and safe resident handling in the sample of 13. This failure resulting in R1 experience severe pain for a period of approximately 4 hours after sustaining a fractured left humerus on 11/11/25 when the staff failed to use a gait belt to reposition R1. Findings include: R1's Face Sheet documented an Admission Date of 11/11/25, a Discharge Date of 11/12/25, and listed diagnoses including Chronic Obstructive Pulmonary Disease, Diabetes Type 2, Congestive Heart Failure, Small Cell B Lymphoma, and Hypertension. R1's November 2025 Physicians Orders documented orders for restorative nursing services daily for bed mobility	S9999		

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S9999	Continued from page 2 and transfers. R1's November 2025 Physicians Orders documented an 11/11/25 order for Tylenol 500 milligrams two tablets four times daily as needed for pain, and an 11/12/25 order for hydrocodone acetaminophen 5-325 milligrams take one tablet four times daily as needed for pain. R1's Transfer Assessment dated 11/11/25 completed by V6, Registered Nurse, documented, "Is the resident Independent in transfers and ambulation? No. Is resident predictable, cooperative, and able to follow directions? No. Is resident able to bear weight well during transfers, do they have history of being able to bear weight? No. Does resident only need minimal assistance (up to 25 # (pounds))? No. Is resident able to put both feet on the base of the Stand Assist Lift and bear some weight? No. Is resident able to lean back into the lifting belt at least a little? No. Is resident cooperative, and able to follow simple directions? No. Can resident bear weight on at least 1 leg well or bear weight moderately well on both legs (up to 5# assistance, or 25# per staff member)? Does resident have history of being able to bear weight and is resident predictable, cooperative, and able to follow directions? No. Use full body (mechanical) lift for all transfer. Consult physical/occupational therapy and Director of Nursing." R1's Functional Abilities Assessment dated 11/11/25, completed by V6, documented, "Sit to stand: Admission Performance: Not attempted due to medical condition or safety concerns. Lying to sitting on side of bed - Admission Performance: Substantial/maximal assistance - Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort." R1's November 2025 Medication Administration Record (MAR) documented an order for Tylenol 500 milligrams two tablets as needed four times daily start date 11/11/25. This MAR documented that the Tylenol was given on 11/11/25 at 9:29pm for 'Pain" and was effective. There was no numeric value documented to rate this pain. The MAR documented the Tylenol was again given on 11/12/25 at 6:35am for "Pain" and was slightly effective. There was no numeric value documented to rate this pain. The MAR documented an order for hydrocodone-acetaminophen 5-325 milligrams take one tablet as needed four times daily with a start date 11/12/25. The MAR documented this medication was given on 11/12/25 at 10:36am and was not effective. There was no numeric value documented to rate this pain. The MAR documented an order for "Pain assessment	S9999		

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S9999	Continued from page 3 every shift." This documented that on evening shift (2pm-10pm) and night shift (10pm-6am) on 11/11/25, R1's pain was zero. On 11/12/25 on the day shift (6am-2pm) R1's pain was 10. R1's Minimum Data Set Pain Assessment dated 11/11/25 at 8:09pm, authored by V6, Registered Nurse (RN), documented "Purpose of assessment: Admission. Complete for all residents, regardless of current pain level. At any time in the last 5 days, has the resident received scheduled pain medication regimen? No. Complete for all residents, regardless of current pain level. At any time in the last 5 days, has the resident received PRN pain medications OR was offered and declined? Yes. Ask resident: 'How much of the time have you experienced pain or hurting over the last 5 days?' Rarely or not at all. Numeric Rating Scale (00-10). Ask resident: 'Please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine.' (Show resident 0-10 pain scale). 4." R1's Nursing Progress Note dated 11/11/23 at 12:23pm, authored by V5, Registered Nurse (RN), documented, "This nurse took report from a nurse at the hospital. Resident is a 79-year-old full code with a history of Prostate Cancer and Atrial Fibrillation. He is here for rehab so he can go back home to live with his wife. Hospital treated him with Intravenous fluid, Continuous Bladder Irrigation, and 1 unit of blood. At time of this report, resident hemoglobin is 9.7. Resident is alert and oriented times 4, very weak, appears pale, is three times a day (glucose check), incontinent of bowels, has a (indwelling urinary catheter) that was changed on the 11/6/25. Resident has a stage 2 pressure sore that they have been treating with zinc. He is a heavy 2 assist, takes pills whole, regular diet, thin liquids." R1's Nursing Progress Note dated 11/11/25 at 7:51pm, authored by V6, RN, documented, "(V3, Certified Nursing Assistant/CNA) reported to me that this resident was being pulled up in his chair around dinner time and as V3 and other aide (V4) went to hook one of their arms under residents arms, and their other hands were used to grab ahold of resident's waist/pants. As resident was being lifted and pulled back up into his chair, (V3) heard 3 'pops' and resident then stated, 'Ow ow ow my arm is broke.' Resident left arm movement is minimal below elbow, and is unable to move above the elbow, especially without serious pain. Resident requested Tylenol for pain. Family was in the room during the entire occurrence and witnessed what had happened. I asked the family about options, such as getting an	S9999		

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S9999	Continued from page 4 x-ray or being sent back to the hospital; I also stated that we currently had (portable x-ray provider) on their way for another resident, and I could see about getting this resident added on to the workload. Family requested resident be seen by x-ray as they 'just left (local hospital) today around 2 and we don't want to go back.' I called (V9, On Call Physician/Medical Director) as he is on call and explained the situation. I stated what the family had requested and asked if it would be okay to add resident to current x-ray trip. (V9) stated that he thought that would be okay and to go ahead with adding them to current workload. I called (x-ray provider) and added this resident to the list, (provider) stated that they would be here between 8:20-8:30 (pm) to do both x-rays." R1's Nursing Progress Note dated 11/12/25 at 8:33am, authored by V8 RN documented, "Called (V10, Primary Care Physician) on his cell. Reported resident pain level of 10 this morning and Tylenol given but family requested something stronger for pain control. Order received for Hydrocodone 5/325 four times daily as needed for pain. Clarification regarding Eliquis needed as family thought MD stopped it. (V10) stated it depends on if family is wanting to pursue palliative care or full treatment, and he will speak with them and then update this nurse. Order to hold Eliquis for now." R1's Nursing Progress Note dated 11/12/25 at 12:02pm authored by V8 stated, "Telephone order received from (V10) at 1056 am to send to ER for evaluation instead of going the referral route. Called (local Emergency Room) report to (name of hospital staff) at 12:00. Called EMS (Emergency Management Systems) at 11:02am, EMS arrived at 11:15 am." R1's Event Report authored by V6 dated 11/11/25 at 7:48pm documented the event as per the 11/11/25 7:52pm Nursing Progress Note as stated above. A Long Term Care Facility Serious Injury Incident Report Initial and Final report for R1 submitted by V1, Administrator, Initial dated 11/11/25 and Final dated12/3/25 documented, "Detailed Incident Summary: Resident was being pulled up in his chair around dinner time and as (V3 and V4) went to hook one of their arms under residents arm and their other hands were used to grab ahold of residents waist/pants. As resident was being lifted and pulled back up into his chair, (V3) heard 3 pops and resident then stated, 'ow ow ow, my arm is broke.' X-ray was performed by (portable x-ray provider) and came back as a pathological fracture due to Osteoporosis."	S9999		

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S9999	Continued from page 5 R1's X-ray Patient Report dated 11/11/25 documented, "Left shoulder: Findings: There is an acute fracture at the proximal shaft of the left Humerus which is suspected to be pathological fracture." R1's 11/12/25 Hospital Discharge Summary documented, "Patient is a 79-year-old male who presents to the Emergency Department via Emergency Management Systems from a local nursing facility for left shoulder pain. Last night he was being moved up in bed when he heard a pop. An X-ray of the left shoulder discovered a pathological fracture of the left humerus. Patient is alert and oriented upon presentation. Per wife and daughter, patient has a history of colon cancer 2003 status post bowel resection, prostate cancer 2016, status post radiation, leukemia 2023, status post chemotherapy - currently in remission. Patient was hospitalized last week for blood in his catheter. He was too weak to work with physical therapy while he was hospitalized so he was discharged to a local nursing facility. Spoke with family about discharge planning. Family wants to take patient home and will not be returning to the nursing facility. They are trying to set up home hospice care at this time. Contacted case management to talk to family. Clinical Impression: Closed nondisplaced fracture of surgical neck of left humerus, unspecified fracture morphology, initial encounter. Disposition: Discharge." R1's Death Certificate documents a date of death of 11/14/25 and a "Cause of Death: Coronary Artery Disease." On 12/31/25 at 8:55 am, V11, Family Member, stated on 11/11/25 around supper time "before 5pm", she asked staff to pull R1 up in his recliner as he was sliding down. V11 stated V3 and another unknown CNA stood on either side of R1, hooked their arms under R1's armpits and lifted, without using a gait belt, and a loud crack was heard from R1's left arm, and R1 stated, "You broke my arm.". V11 stated V3 immediately left the room to inform the nurse what had happened. V11 stated at that time R1 did not complain of pain unless he moved his arm. V11 stated V3 came in and looked at the arm every 10 minutes or so in between time and said she was checking for swelling and bruising. V11 stated V6, Registered Nurse, came into the room to evaluate the arm at around 7pm. V11 stated V6 then called the on-call physician and got an order to have the arm x-rayed, which showed that it was fractured. V11 stated V3 stated the on-call physician recommended not sending R1 to the local Emergency Room (ER) as no Orthopedic services were available there but waiting until the next morning so an emergent appointment could be made	S9999		

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S9999	Continued from page 6 with an Orthopedic Surgeon. V11 stated that V11 and V12 were in agreement with that plan as R1 had just gotten out of the hospital on 11/11/25 and they felt it would be hard on him to have to go back unless it was needed. V11 stated as time wore on in the evening, R1 was in, “Horrible pain, moaning, and screamed out when they repositioned him to change him.” V11 stated sometime around 9pm, V6 gave R1 two Tylenol and stated that was the only thing R1 had ordered for pain. V11 stated she asked V6 if R1 could have some stronger pain medication, and V6 stated trying to get an order for narcotic pain medication at that time of the day was, “A whole big thing.” V11 stated R1 did get some relief from the Tylenol and was able to sleep. V11 stated by the next morning, R1 was in severe pain. V11 stated V8, RN, contacted V10, R1’s Physician, about getting stronger pain medication but it was not administered until after 10:30am on 11/12/25. V11 stated staff were also trying to get R1 an orthopedic appointment that morning. V11 stated by that time she and R1 were tired of waiting on the referral and tired of seeing R1 in pain and asked V8 that R1 be sent to the local ER to make sure he would have access to needed pain medication. V11 stated R1 was discharged to home from the hospital on 11/12/25 on hospice care and died on 11/14/25. V11 stated it is her belief that the fracture and resulting pain caused R1 to, "Give up," and this contributed to his death. On 12/31/25 at 10:50am, V3 stated on 11/11/25 she worked 2pm-10pm. V3 stated R1 was a new admission who arrived about the same time as when she started her shift. V3 stated V11, V12, and V13, Family Members, were in the room with R1. V3 stated R1 was alert but somewhat confused, calling out for V12 although she was in the room. V3 stated around 4:30pm, V11 put on the call light and said R1 needed moved up in the recliner. V3 stated she and V4 got on either side of the recliner, put their arms under R1’s armpits, and lifted. V3 stated a gait belt was not used. V3 stated, “They all heard 3 loud pops, and (R1) said oh I think you broke my left arm.” V3 stated she immediately left the room and told V5, RN, what had happened. V3 stated V5 asked if the arm was swelling and V3 said no. V3 stated V5 said she would be down there as soon as she got finished with what she was doing. V3 stated as V5 did not go assess R1, V3 was checking in and looking at his arm every 10 minutes or so. V3 stated R1 stated he had no arm pain as long as his arm was immobilized but had significant pain if it was moved. V3 stated V5 left the facility when her shift ended at 6pm without having assessed R1. V3 stated at about 6:30pm she told the oncoming nurse, V6, RN, what had happened and V6 then went and assessed R1.	S9999		

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S9999	Continued from page 7 On 12/31/25 at 12:40pm, V4 corroborated V3's account of the incident, with V4 stating she stood on the right side of the recliner with V3 on the left side. V4 stated after a pop was heard, V3 left the room to tell the nurse working that night, identity unknown, what had happened. V4 stated she was engaged in caring for other residents for the remainder of her shift and was not sure what happened with R1 the remainder of the evening. On 12/31/25 at 1:10pm, V13, Family Member, stated on 11/11/25 when she was visiting R1, V3 needed to get R1 into bed using a mechanical lift. V13 stated V3 left the room to get help from other staff, but nobody was available. V13 stated she offered to help with the lift and V3 accepted, with V3 using the controls and V13 helping with positioning in the bed. V13 stated the transfer was uneventful. On 12/31/25 at 2:15pm, V3 corroborated V13's account of the mechanical lift transfer as stated above. V3 stated two staff are to do mechanical lift transfers, but other staff were busy and V13 offered to help. On 12/31/25 at 2:20pm, V6 stated she worked 6pm-10pm on 11/11/25. V6 stated shortly after arriving, V3 stated to V6, "There was a popping noise from (R1's) arm when they pulled him up in the chair around supper and asked if I could go down to see him ASAP (As Soon As Possible) as he was in pain." V6 stated V3 told V6 that she had told V5 about it earlier, but V3 thought V5 forgot. V6 stated V11, V12, and V13 were present in R1's room when she went in. V6 stated the arm wasn't bruised or swollen and was not painful if immobile but there was pain with movement as well as decreased range of motion. V6 stated she did not recall asking R1 what his pain was on a ten scale but did ask if he wanted anything for pain and he said yes, Tylenol, for which he had an order. V6 stated she called V9, who ordered an x-ray. V6 stated she administered the Tylenol she thinks at about 7pm and recalls later the resident felt it had been effective. V6 stated the x-ray result came back toward end of her shift showing a pathological fracture of the left humerus. V6 stated she notified V9 of the result, who stated he did not feel R1 needed to be sent to the local ER, as they had no orthopedic services, but to wait until the next day and get him an appointment with an orthopedic surgeon. V6 stated she notified V11, who was in agreement with this plan. V6 stated V11 stated R1 had just gotten out of the hospital and didn't want him to return if it wasn't necessary. V6 stated the rest of her shift, in regard to R1, was uneventful.	S9999		

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S9999	Continued from page 8 On 1/7/26 at 8:30am, V7, RN, stated she worked 10pm to 6am on 11/11/25. V7 stated she had been informed of R1's condition during shift report. V7 stated she did not recall doing a pain scale on R1 or the specific severity of his pain. V7 stated she recalled R1 was guarding the arm and didn't want it moved. V7 stated she was not sure if she administered Tylenol, but upon checking R1 he was sleeping soundly, and she assumed he was not having severe pain. V7 stated she asked V11 if V11 felt R1 needed to go to the ER and V11 said no. V7 stated V11 nor R1 asked for stronger pain medication at any time during the shift. V7 stated she regularly works the night shift and obtaining narcotic pain medication can be difficult. V7 stated it is difficult to get the on-call physicians to prescribe opiates for residents that are not their patients, and they expect primary care physicians to address this during daytime hours. V7 stated a written prescription is required and a verbal order can't be used. V7 stated if there is a written order sent to the pharmacy, the facility can call the pharmacy and get a code for which to obtain the medication from the Emergency Medication Kit (E-Kit). On 1/7/26 at 9:15am, V5 stated she thinks she worked 2pm-6pm on 11/11/25. V5 stated R1 had just been admitted, and she recalled going into the room with consents for him to sign and V11 was also present. V5 stated R1 was able to appropriately answer questions but was not talkative and V11 did most of the talking. V5 stated she had no further contact with R1 that shift. V5 stated about 30 minutes before time to leave for the day, she was passing medications on A Hall when V3 came to her and said, "They had attempted to pick (R1) up, and he felt something pop." V5 stated she told V3 she would assess R1 after she finished medication pass. V5 stated she forgot about it, did not assess R1, and did not tell the oncoming nurse about it in report. V5 stated, "Only about 30 minutes elapsed from when (V3) told her about it until her shift was over and she left." V5 stated V3 did not express to her that the arm might be broken, and if she had she would have locked up the medication cart and went down there immediately. On 1/7/26 at 11:05am, V9 stated staff called him (time unknown) on the evening of 11/11/25 to report that when R1 was being repositioned in a chair, a pop was heard. V9 stated he ordered a portable x-ray which showed a pathological transverse fracture of the left humerus. V9 stated such fractures are generally treated with external stabilization, such as sling, rather than surgical intervention. V9 stated based on this, as well as a lack of availability of orthopedic services at the	S9999		

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S9999	Continued from page 9 nearby ER, he felt there was no indication to send R1 out but to instead obtain an appointment with an orthopedic surgeon the next day. V9 stated staff told him the family agreed with this plan as they wanted to avoid rehospitalization if possible. V9 stated had the family wanted R1 sent out, he would have done so immediately. V9 stated staff did not say that R1 was in severe pain and needed narcotic pain medication or he would have provided it. V9 stated an e-script (electronic prescription) could have been sent to the pharmacy and a code given for the e-kit. On 1/7/26 at 11:55am, V8, RN, stated she came in to work at 6am on 11/12/25 and was given report by V7, who stated R1 had a left arm fracture which occurred after CNAs lifted him up by arms to reposition him in the chair. V8 stated V7 said the family and V9 had planned to get R1 an orthopedic referral that morning. V8 stated within about 30 minutes after report she went to check on R1 and found he was in severe pain, at a 10 on a 10 scale. R1 and V11 were unable to say how long the pain had been going on. V8 checked R1's orders and found there was only Tylenol ordered, so she went ahead and gave it about 6:30am, and upon checking back, found it had been mostly ineffective. V8 stated she did not recall what R1's pain was on a ten scale at that point or if she asked. V8 stated she called V10, R1's Primary Care Physician, who ordered Norco for R1's pain. V8 stated since V10 was not in his office with the ability to send an e-script, she could not get a code from the pharmacy to get into the e-kit until after 10am. V8 stated by that time, V11 and R1 were very upset and wanted R1 sent out. V8 stated she got an order to send R1 out from V10 at about 11am and the ambulance arrived about 11:15am. V8 stated with their current pharmacy services, getting medications, especially narcotics is often difficult. On 1/7/26 at 12:35pm, V10 stated he last saw R1 on 11/11/25 as he was discharging R1 from the hospital. V10 stated R1 had multiple serious chronic health problems including Prostate Cancer and Lymphoma. V10 stated to his knowledge there was no metastasis to the bones nor did R1 have osteoporosis. V10 stated the plan was for R1 to receive rehab services at the facility and return home with V11. V10 stated R1 was weak but stable and was on a lot of medications. V10 stated he was surprised to learn of the arm fracture. V10 stated in his weakened state, R1 would not have been able to assist staff with repositioning and with a gait belt not being used, it most likely caused the fracture. V10 stated when R1 returned to the ER on 11/12/25, he deteriorated and was sent home on hospice later that same day. V10 said he was surprised to learn that R1	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0050757	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF OLNEY	410 EAST MACK , OLNEY, Illinois, 62450

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S9999	Continued from page 10 died on 11/14/25. V10 stated the cause of death per the death certificate was coronary artery disease. V10 stated when the incident was reported to V5, R1 should have been immediately assessed for injury and pain V10 stated the facility, “Could have done a better job of taking care of this patient.” V10 stated he was not aware of any ongoing issues with resident’s medications being available, including opiates. V10 stated V8 called him the morning of 11/12/25 saying R1 was in severe pain and got a verbal order for Norco for R1. V10 stated he cannot e-script from his phone, so he was able to do that from his office at 10:20am. V10 stated it was his understanding that opiates could be obtained from the e-kit with a verbal order. On 1/7/26 at 2pm, V14, Certified Occupational Therapy Assistant/Therapy Services Director, stated she did not evaluate R1 and could not speak directly as to his care, but current recommendations for a similar resident would be repositioning with a gait belt, not by lifting under the arms. On 1/8/26 at 8:30am, V2, Director of Nurses, stated it is the facility’s policy that repositioning a resident in a situation such as R1 requires the use of a gait belt. V2 stated it was her understanding that V6 assessed R1 instead of V5 as the incident occurred at shift change around 6pm. V2 stated it was her understanding that V3 did not relay to V5 how serious R1's situation potentially was and that he most likely had a fracture. V2 stated had the family wanted R1 sent out, V9 would have given the order to do so, but they had stated they wanted to avoid rehospitalization if possible. V2 acknowledged getting narcotics and medication for new residents with their current pharmacy is at times problematic. The facility’s Safe Patient Handling Policy dated 9/8/23 stated, “Policy: All resident care will be provided in a safe appropriate and timely manner in accordance with the individual resident's care plan. Manual lifting of all residents who are unable to bear weight will be minimized. Residents identified as totally dependent or extensive assistance, for example will be transferred by means of lift equipment and/or other resident assist devices instead of by manual lift. Gait/transfer belts, including two handled gait/transfer belts where deemed appropriate, will be used where manual assistance is required for ambulation and transfer activities. The facility’s Repositioning of Resident Policy dated 5/2/19 documented, “Repositioning a resident in a chair: 6. Prevent skin to skin contact with use of	S9999		

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S9999	Continued from page 11 sheets, pillows, or positioning devices." The facility's Mechanical Lift Policy dated 9/8/23 documented, "Two staff members are required when transferring a resident with a mechanical lift." The facility's Resident Examination and Assessment Policy dated February 2014 documented, "The purpose of this procedure is to examine and assess the resident for any abnormalities in health status, which provides a basis for the care plan. Physical Exam: Musculoskeletal: A. Gait. B. Mobility and range of motion of extremities. C. Joint deformity. D. Fractures." The facility's Gait Belt Use Policy dated July 2014 documented, "Policy: It is the policy of (the facility) that gait belts will be used when staff are transferring weight bearing residents or assisting them with walking for the safety of the resident and the employee. Procedure: 5. When transferring the resident use good body mechanics, bend knees, not back, reach under the residents' arms and hold the gait belt behind his/her back." The facility's Pain Prevention and Treatment Policy dated 10/10/23 documented," Certain medical conditions may be painful, including: Musculoskeletal conditions: Fractures. Procedure: Each resident will be assessed for pain including an appropriate pain rating scale upon admission and at least quarterly. A. Residents capable of answering yes/no questions will be assessed using Wong-Baker, Numeric Scale, or similar form in the Electronic Health Record. After completion of the assessment, the resident will receive interventions to reduce or alleviate the pain. These interventions may be non-pharmacological or pharmacological (with physician's order)." (A)	S9999		