STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000405	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EFFINGHAM HEALTHCARE & SENIOR LIVING	**1610 NORTH LAKEWOOD DRIVE , EFFINGHAM, Illinois, 62401**

(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 Facility Reported Incident of November 26th, 2025 / 2693292	S0000		01/03/2026
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 care needs of the resident. d) Pursuant to subsection (a), general nursing care	S9999		

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

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S9999	Continued from page 1 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 regulations were not met as evidence by: Based on interview and record review, the facility failed to provide a safe mechanical lift transfer for 1 (R1) of 3 residents reviewed for accidents in the sample of 5. This failure resulted in R1 acquiring a laceration to her head on the top left side resulting in 2 sutures being placed. This past noncompliance occurred between 11/26/25 and 12/1/25. Findings include: R1's Admission Record documented an admission date of 11/10/2025 and diagnoses including chronic systolic heart failure, type 2 diabetes mellitus without complications, morbid (severe) obesity due to excess calories, and adult failure to thrive. R1's Minimum Data Set (MDS) dated 11/16/2025, documented under section C- (cognitive patterns) a BIMS (Brief Interview for Mental Status) of 15, indicating R1 was cognitively intact. This same document under section GG- Mobility documented that R1 is dependent, which means helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort for a chair/bed-to chair transfer. R1's Care Plan documented a focus area of R1 having limited physical mobility related to weakness, morbid obesity, osteoarthritis, restless leg syndrome, hypertension, spinal stenosis, gout, and left tibia fracture, pain, change in cognitive status, visual impairment, mood, incontinence with an intervention of chair/bed-to-chair transfer: The resident is dependent by 1-2 staff. On 12/23/2025 at 10:04 AM, R1 stated that on 11/26/2025, V3 (Licensed Practical Nurse/LPN) and V4 (Certified Nurse Assistant/CNA) had been in the process of transferring her from a shower chair to her bed via	S9999		

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S9999	Continued from page 2 mechanical lift. R1 stated, during the transfer, V3 and V4 were having trouble getting the wheels to move on the mechanical lift. R1 stated, while being guided to her bed, elevated in the sling, she could see the mechanical lift starting to tip over. R1 stated, she landed on the floor beside her bed, hitting her bottom and heels on the floor, and the mechanical lift hit her in the head causing a laceration. R1 stated, she had been sent to the local emergency room where she received 2 staples to the top left side of her head. On 12/23/2025 at 10:29 AM, V3 (LPN) stated she had been assisting V4 (CNA) in the afternoon on 11/26/2025 transfer R1 from a shower chair to her bed via mechanical lift. V3 stated, she had been the operator of the mechanical lift while V4 was guiding R1. V3 stated, the mechanical lift had been hard to maneuver with R1 in the sling. V3 stated, during the transfer with R1 elevated in the sling, R1's weight became unbalanced when V4 repositioned R1 for the bed while lift was still in motion causing the mechanical lift to tip over. V3 stated, R1 landed on her buttock in the floor and the mechanical lift hitting R1 in the top left side of her head causing a laceration. On 12/23/2025 at 10:56 AM, V4 (CNA) stated, her and V3 (LPN) had been transferring R1 from a shower chair to her bed via mechanical lift on 11/26/2025 in the afternoon. V4 stated, during R1's transfer she had been guiding R1 while V3 operated the mechanical lift. V4 stated, R1 had been close to the weight limit for the mechanical lift of 450 pounds. V4 stated, while guiding R1 while elevated in the sling she turned R1 to position for the bed, R1's weight became unbalanced causing the mechanical lift to tip over. V4 stated, R1 fell to the floor, hitting her buttock and heels on the ground next to her bed and the mechanical lift hit R1 on the top left side of her head causing a laceration. On 12/24/2025 at 10:45 AM, V4 stated and further clarified that there was a lack of communication between her and V3 during R1's transfer. V4 stated, she had repositioned R1's legs too soon during the transfer while lift was still in motion, which caused the mechanical lift to tip over. On 12/23/2025 at 11:46 AM, V2 (Director of Nursing/DON) stated she had been working the day R1 had fallen with the mechanical lift. V2 stated, V3 and V4 notified her that in the process of transferring R1 from a shower chair to her bed via mechanical lift the lift had tipped over with R1 in the sling causing a laceration to the top left side of her head. V2 stated, the investigation determined that R1's weight became	S9999		

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S9999	Continued from page 3 unbalanced during the transfer causing the mechanical lift to tip over. On 12/23/2025 at 11:50 AM, V1 (Administrator) stated she had been notified by V2 that V3 and V4 had been in the process of transferring R1 from a shower chair to her bed via mechanical lift and the lift had tipped over with R1 elevated in the sling causing the lift to hit the top left side of R1's head. V1 stated the investigation determined that R1's weight became unbalanced during the transfer during repositioning and motion of lift and caused the mechanical lift to tip over. On 12/23/2025 at 12:05 PM, V5 (Physical Therapy Assistant/PTA) stated, the mechanical lift could tip over if R1's weight had become unbalanced outside the base center of the mechanical lift during transfer. R1's Progress Note dated 11/26/2025 at 5:55 PM documented R1 was transferring with 2 staff members from shower chair to bed. Resident sustained a fall. Laceration noted to left top of head…. Resident sent to ER (emergency room) for evaluation and treat. R1's Progress Note dated 11/26/2025 at 6:30 PM documented R1 returned to facility from local hospital in ambulance accompanied… R1 had new orders to remove staples from laceration in 7 days. R1's after visit hospital summary dated 11/26/2025 documented under history of present illness…mechanical lift flipped over, patient landed on her bottom, mechanical lift struck her in the left side of head, laceration to scalp and under physical exam weight of 437 pounds. This same document under laceration repair dated 11/26/2025 at 4:34 PM performed by V15 (Emergency Room Physician) to the left parietal scalp area, 2.5 centimeters (cm) in length, repair method of 2 staples. The facility's incident investigation report dated 11/26/2025 documented R1 had been in the process of being transferred via mechanical lift by V3 (LPN) and V4 (CNA). R1 had been being pushed toward the bed when the mechanical lift became unbalanced with resident still elevated in sling. R1 did experience a fall and sustained a laceration to the left top of head. Resident was sent to the local emergency room (ER) for evaluation and treatment. Resident returned from the ER with two staples and orders to remove in 7 days. The facility policy titled "Lifting Machine, Using a Mechanical Lift" (undated) documented under Purpose "The purpose of this procedure is to establish the	S9999		

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S9999	Continued from page 4 general principles of safe lifting using a mechanical lifting device. It is not a substitute for manufacturer's training or instructions. Steps in Procedure 16. Gently support the resident as he or she is moved, but do NOT support any weight." On 12/23/25 at 11:50 AM, V1 (Administrator) provided their QAPI (Quality Assurance Performance Improvement) Ad Hoc Form outlining the actions taken by the facility prior to the survey date to correct the noncompliance. Prior to the survey date, the facility took the following actions to correct the non-compliance: 1. A Quality Assurance and Performance Improvement meeting was held on 12/1/25. In attendance - V1, V2, V3, V12 (Regional Director), and V13 (LPN/MDSC - Minimum Data Set Coordinator). 2. Process/Steps to identify others having the potential to be impacted by the same deficient practice: All residents that are transferred per mechanical lift. 3. Measures put into place/systematic changes to ensure the deficient practice does not recur: V2 and V15 (ADON) provided in-service to nursing staff on mechanical lift/safe transfers and return demonstration on use of mechanical lift. Completed on 12/1/25. All beds checked and ensured they are locked. 4. Plan to monitor performance to ensure solutions are sustained: V2 (DON) will complete observations of 3 lift transfers weekly for 6 weeks. Should any concerns be identified, during transfer, V2 will immediately intervene and provide additional education with return demonstrations. The first complete facility audit was completed on 12/1/2025 by V2. "B"	S9999		