STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145887	A. BUILDING _____ B. WING _____	C 08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAUCONDA HEALTHCARE AND REHAB	**176 THOMAS COURT WAUCONDA, IL 60084**

(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
F 323	Continued From page 1 using the same pieces of equipment, the total body lift and the shower chair. E3 stated R1 was placed in the sling while in her bed, lifted and moved toward the shower chair. E3 demonstrated how R1 was in the lift, directly over the shower chair with E4 behind the chair, guiding R1. Suddenly, the overhead bar holding the sling dropped. The lift then tipped backwards and the overhead bar hit R1 on the back occipital area causing a laceration. Other staff were immediately called and assisted in lifting the lift off of R1. On 8/15/13 at 11:45am, R1 stated she did recall the incident and that it happened so fast. R1 stated it was not anyone's fault and she does not currently have any discomfort from the accident. Review of facility's weekly lift and ceiling hoist maintenance log shows this lift, #2, (the facility has 3) was taken out of order from 6/4/13 through 6/11/13 for a " lift replacement handle. " E7 (Activity/Rehab aide) stated this is the same piece of equipment that failed on 8/10/13. E7 said the lever that locks the base slipped due to a worn locking mechanism, causing the overhead bar to drop. E1 (administrator in training) stated on 8/15/13, the mechanical lift has been permanently taken out of service.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210b) 300.1210d)6) 300.2420j) 300.3240a)	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145887	A. BUILDING _____ B. WING _____	C 08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAUCONDA HEALTHCARE AND REHAB	**176 THOMAS COURT WAUCONDA, IL 60084**

(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
F9999	Continued From page 2 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. 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. Section 300.2420 Equipment and Supplies j) There shall be a sufficient quantity of resident care equipment of satisfactory design and in good condition to carry out established resident care procedures. This shall include at a minimum the following: wheelchairs with brakes, walkers, metal bedside rails, bedpans, urinals, emesis basins, wash basins, footstools, metal commodes, over the lap tables, foot cradles, footboards, under the mattress bed boards, trapeze frames, transfer boards, parallel bars and reciprocal pulleys. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145887	A. BUILDING _____ B. WING _____	C 08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAUCONDA HEALTHCARE AND REHAB	**176 THOMAS COURT WAUCONDA, IL 60084**

(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
F9999	Continued From page 3 resident. (Section 2-107 of the Act) These requirements are not met as evidenced by: Based on observation, record review and interview, the facility failed to maintain a mechanical lift in safe condition for 1 of 3 residents reviewed for resident transfers. This failure resulted in R1 receiving a head laceration being sent to the emergency room and receiving 13 sutures. Finding includes: Review of facility's final report submitted to IDPH dated 8/13/13 shows R1 was being transferred from her bed to a shower chair using a total body lift by two nurse's aides, E3 and E4. The lift dropped suddenly while R1 was being lowered into the shower chair. The lift hit the head of the resident resulting in a laceration of 6 cm. R1 remained alert and oriented with no change in consciousness. R1 was sent to the ER and returned a few hours later with 13 stitches to the scalp. E3 and E4, nurse's aides who were involved in this transfer, were interviewed on 8/15/13 at 12:50pm and a re-enactment was performed using the same pieces of equipment, the total body lift and the shower chair. E3 stated R1 was placed in the sling while in her bed, lifted and moved toward the shower chair. E3 demonstrated how R1 was in the lift, directly over the shower chair with E4 behind the chair, guiding R1. Suddenly, the overhead bar holding the sling dropped. The lift then tipped backwards and the overhead bar hit R1 on the back occipital area causing a laceration. Other staff were immediately called and assisted in lifting the lift off of R1. On 8/15/13 at 11:45am, R1 stated she did recall	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145887	A. BUILDING _____ B. WING _____	C 08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAUCONDA HEALTHCARE AND REHAB	176 THOMAS COURT WAUCONDA, IL 60084

(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
F9999	Continued From page 4 the incident and that it happened so fast. R1 stated it was not anyone's fault and she does not currently have any discomfort from the accident. Review of facility's weekly lift and ceiling hoist maintenance log shows this lift, #2, (the facility has 3) was taken out of order from 6/4/13 through 6/11/13 for a " lift replacement handle. " E7 (Activity/Rehab aide) stated this is the same piece of equipment that failed on 8/10/13. E7 said the lever that locks the base slipped due to a worn locking mechanism, causing the overhead bar to drop. E1 (administrator in training) stated on 8/15/13, the mechanical lift has been permanently taken out of service. (B)	F9999		