STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510054	A. BUILDING: _____ B. WING _____	C 08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD - BLOOMINGTON	14 HEARTLAND DR BLOOMINGTON, IL 61704

(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
A 000	Initial Comment Original investigation of Complaint 2466680 / IL 177037. 295.6000 a) 13) cited.	A 000		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Section 295.6000 Resident Rights a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of an establishment, nor shall a resident forfeit any of the following rights: 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor; TYPE 1 VIOLATION Based on record review and interviews, the establishment neglected to safely transfer one of three sampled residents from wheelchair to the bed using a mechanical lift. (R1) is failure resulted in R1 suffering a subarachnoid hemorrhage and subsequently dying. Findings include: Facility incident report dated 8/21/24 reads, "Resident (R1) was being transferred from her chair to her bed via (Mechanical Lift). Somehow the resident (R1) slipped out of the sling and fell on the floor hitting the (Mechanical Lift) as well.	A6000		

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A6000	Continued From page 1	A6000		

She (R1) has a hematoma on the right side of her forehead and a gash on her left lower inner leg. The leg was wrapped by the floor nurse (E5) to stop the bleeding. Vitals were taken. Hospice was called and notified. Floor nurse called POA (Z1) several times and left voicemails. The floor nurse called hospice back and described the injury over the phone and they agreed the resident (R1) should go to the E.R. to be evaluated. Second emergency contact was notified by the floor nurse and informed (R1) was going to the E.R.."

On 8/23/24 at 11:20 A.M., E4 (Caregiver) stated that on 8/21/24 E3 (Caregiver) had asked for E4's help transferring R1 from her wheelchair to her bed. E4 stated that the sling was already under R1, so they hooked up the four straps to the mechanical lift. E4 stated that he was controlling the raising part of the lift. E4 stated as he raised R1 up in the lift, just as soon as E3 pulled the wheelchair out from under R1, R1 fell to the floor. E4 stated that he could see R1 was injured, so he ran to get the nurse (E5) to come and evaluate R1. E4 stated that when he came back into R1's room he noticed that the right side strap was unhooked from the mechanical lift. E4 stated that he assumed the strap must have slipped off.

On 8/23/24 at 12:10 P.M., E3 stated that on 8/21/24, E4 had come into R1's room to help transfer R1 from her wheelchair to her bed using a mechanical lift. E3 stated that the sling was already under R1 in the chair, so they hooked up all four straps of the sling to the mechanical lift. E4 was controlling the lift while E3 was going to pull the wheelchair out from under R1. E3 stated that when E4 raised R1 in the sling, E3 pulled the wheelchair out from under R1. E3 stated just as she pulled the wheelchair out, the right shoulder strap came off and R1 fell. E3 stated that R1 hit

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A6000	Continued From page 2 her head on the lift legs and cut her leg open. E3 notice a large lump on R1's forehead. E3 stated that the strap must not have been secured around the hook properly. ED to Hospital - Admission Discharge summary notes R1's "Principal Problem : Subarachnoid Hemorrhage. Active problems: Acute respiratory failure with hypoxia, Acute chronic anemia. Cause of death: Acute hypoxic respiratory failure possibly associated with aspiration versus PE." On 8/26/24 at 9:39 A.M., Z1 (R1's Sister and POA) stated that when R1 was in the hospital, the physician had told her that due to R1's head injury form the fall, it has affected her respiratory condition, so they chose to just keep her comfortable. Z1 stated that the physician said that it was all the complications related to the fall that caused her death. Z1 stated that she knew that R1 would not have wanted to be intubated and placed on mechanical ventilation.	A6000		