STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015382	A. BUILDING: _____ B. WING _____	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLNSHIRE ASSISTED LVG CTR	170 JAMESTOWN LANE LINCOLNSHIRE, IL 60069

(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
S 000	Initial Comments Complaint investigation #2212897/ IL 145756	S 000		
S9999	Final Observations Statement of Licensure Violations 330.4210a) 330.710a) Section 330.4210 General a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law based on their status as a resident of a facility. (Section 2-101 of the Act) Section 330.710 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 with the involvement of the administrator. The written policies shall be followed in operating the facility and shall be reviewed at least annually by the Administrator. The policies shall comply with the Act and this Part. This REQUIREMENT was not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure a wheelbound resident was transported in a safe manner for 1 of 3 residents (R1) reviewed for safety in the sample of 3.	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

The findings include:

According to R1's electronic medical records her diagnoses includes, cognitive communication deficit, dementia with behaviors, psychosis, depression and a history of falling.

On 4/14/22 at 10:00 AM, R1 was sitting by the nurses station in her wheel chair with the foot rests attached to the wheelchair and her feet positioned on them. R1 had some faded bruises around her eyes.

On 4/14/22 at 12:50 PM, V1 (Administrator) showed this surveyor security video footage of R1's fall. The date and time on the video was 4/3/22 at 3:37 PM. The video shows V8 (Activity Aid) at the 1st floor elevator with R1 in her wheelchair. R1's left side was facing the opening of the elevator, and V8 appears to be trying to keep one of her legs in the elevator and at the same time grabbing R1's wheelchair and advancing it forward before turning the wheelchair to enter the elevator. When V8 advanced R1's wheelchair forward, R1 fell forwards falling out of the wheelchair on to the ground. V8 could not catch R1 because she (V8) was on the wheelchair's left side with one leg in the elevator. The wheelchair appears not to have the footrests attached.

On 4/14/22 at 2:50 PM, V8 said, she was returning R1 back to her unit after an activity (R1 watched a movie). V8 said, she had one leg in the elevator to keep the doors from closing and was trying to pull R1 into the elevator when R1 fell forward on to the floor. V8 said, R1's footrest were not on. V8 said she was not aware that R1 had fallen from her chair in the past and was

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S9999	Continued From page 2 supposed to have her footrests on while being transported in her wheelchair. V8 said if she needs to know how to transport a resident she can ask at nurse or a CNA(Certified Nursing Assistant) or she can look in the electronic medical records. On 4/14/22 at 10:30 AM, V3 (Clinical Director) said, "our staff don't always put the footrests on the wheelchairs for activities or for rehabilitation." On 4/14/22 at 10:50 AM, V5 CNA said, R1 is an assist with one staff and a gait belt. V5 said R1 sometimes leans in her wheelchair and she'll have to prop R1 up with a pillow. V5 said when R1 gets tired she has poor trunk control. On 4/14/22 at 11:53 AM, V6 (Activity Aid) said, if she needs the foot rest on a resident's wheel chair she will have the CNA put them on. V6 said the footrest should be on if the activity aids are transporting a resident. On 4/14/22 at 3:00 PM, V7 (Nursing Supervisor) said, she did a head to toe assessment on R1 on 4/3/22 at 3:45 PM and noticed a lump on R1's forehead and called the Physician who gave the order to send R1 out to the ED (Emergency Department). R1's Progress Notes shows on 8/31/21, and 1/13/22, R1was being transported by staff in her wheelchair and she (R1) dropped her feet to the floor causing her to fall to the ground. R1's 1/4/22 Care Plan for High Risk of falls related to abnormalities of gait, show to have leg rest on at all times during transport. The leg rest may be removed during activities. Continue to educate new and old staff about leg rest.	S9999		

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S9999	Continued From page 3 R1's 4/4/22 POS (Physician Order Sheets) shows, while (R1) is up in her wheelchair to make sure her footrests are on for safety. The 4/2022 activity calendar shows the activity on 4/3/22 at 2:00 PM was a movie with popcorn. Not an activity that the foot pedals should be removed. The 7/28/21 Fall Occurrence Policy and Procedure shows, resident identified as high risk for falls will be provided interventions to prevent falls. R1's Fall Risk Evaluation dated 1/13/22, and 4/3/22 shows R1 to be a high risk for falls. The Residents' Rights for People in Long-Term Care Facilities shows the facility must provide services to keep the residents' physical health at the highest practical level, and must care for the resident in a manner that promotes quality of life. A policy for transferring residents in wheelchairs was requested but not received. (B)	S9999		