STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015457	A. BUILDING: _____ B. WING _____	C 02/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE FOREST PLACE	1100 PEMBRIDGE DRIVE LAKE FOREST, IL 60045

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S 000	Initial Comments FRI of 1/26/2022\IL143878	S 000		
S9999	Final Observations Statement of Licensure Violations 3001210b) 300.1210c) 300.1210d)6 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. 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: 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 and assistance to prevent accidents. These Requirements were not met as evidenced by: Based on interview and record review the facility failed to ensure a resident was transferred in a safe manner for 1 of 3 residents (R1) reviewed for safety in the sample of 3. This failure resulted in R1 sustaining transverse tibial and fibular fractures. The findings include: R1's Minimum Data Set (MDS) dated 1/21/22 shows R1 is severely cognitively impaired and dependent of two staff for transfers and bed mobility. This same MDS shows R1 has impairment on both sides of her upper and lower extremities. The facility's Incident and Accident Report dated 1/26/22 shows "R1 is 77 yrs old, has diagnoses of Alzheimers disease, history of a traumatic brain injury, seizures, and hospice, is non-ambulatory, and a total body lift with two assist for transfers. On 1/26/22 PM shift Certified Nursing Assistant (CNA) reported she was preparing to get R1 up for dinner. Noted R1's left lower extremity was larger than the right lower extremity. R1 was wearing slipper socks at the time which were not removed. CNA did not assess any further at this time. R1 nonverbal but had facial grimacing and shaking when turned from back to side for changing....R1 was total body lifted back to bed after dinner. CNA removed R1's slipper socks for evening care. R1 noted to have swelling and purplish colored bruising to left ankle and foot. Left lower extremity was warm to touch compared	S9999		

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S9999	Continued From page 2 to right lower extremity. Nurse and Nursing supervisor notified....Investigation into incident- 2 CNA's went to R1's room the morning of 1/26/22 to give shower. R1 had slid down in reclining chair off of the total body lift sling and was sliding out of the chair. The 2 CNA's did a manual body lift of R1 into the shower chair so she would not fall. R1 was showered and then 2 CNA's did manual body lift of R1 back into bed. CNA did not report.....Doctor was notified and orders obtained for an x-ray of left ankle." On 2/23/22 at 11:10 AM, V2 Assistant Director of Nursing (ADON) said she did the investigation and the report of the incident with R1. V2 said she interviewed the staff that worked with R1 on 1/26/22 during the day to see when the ankle fracture could have transpired. V2 said V4 CNA (R1's assigned CNA that day) gave R1 a shower in the morning. V2 said V4 reported when she went to transfer R1 to the shower chair, R1 was not on the total body lift sling. When R1's reclining chair was raised up, R1 was sliding out of the chair. V2 said V4 with V5 CNA's help, manually lifted R1 up and into the shower chair and gave R1 a shower. R1 was then manually lifted from the shower chair to R1's chair. V2 said V4 and V5 reported they did not notice anything with R1's legs or ankle. V2 said neither V4 or V5 reported the incident. V2 said R1 is a mechanical lift transfer with two persons. V2 said V4 and V5 should have called for help to transfer R1. V2 said V4 and V5 were written up for not following R1's Care Plan for the proper way to lift R1 and for not notifying anyone of the incident. V2 said this was the only unusual occurrence that happened to R1 that day the ankle fracture was found. On 2/23/22 at 12:15 PM, V4 CNA said herself and	S9999		

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S9999	Continued From page 3 V5 CNA were preparing to transfer R1 to the shower chair for a shower. V4 said the total body lift sling was only half under R1's bottom and was not positioned correctly . V4 said when the head of R1's chair was raised up, R1's bottom began sliding down the chair. V4 said both herself and V5 grabbed R1 by the arms, catching R1 before she hit the floor. V4 said her and V5 lifted R1 up from the chair and then transferred R1 over to the shower chair. V4 said everything happened so fast, R1 didn't hit the floor but she could not recall the positioning of R1's legs/feet during the incident. V4 said she gave R1 a shower and than manually transferred R1 from the shower chair to the bed with another CNA by grabbing R1's arms. V4 said she should have transferred R1 using the total body mechanical lift to be safe. On 2/23/22 at 10:55 AM, V5 CNA said she was helping V4 with R1's transfer for a shower. V5 said R1 was in her reclining chair and when the chair was raised up, R1 slid down the chair. V4 said they caught R1 when R1's bottom was barely on the edge of the chair but R1 did not fall on the floor. V5 said her and V4 grabbed R1 by the arms (one CNA on each side) and lifted R1 up and then swung R1 over to the shower chair. V5 said she could not recall where R1's legs or feet were during the transfer. V5 said V4 took R1 for a shower and she didn't help with R1 after that. V5 said they should have reported what happened to the nurse. V5 said were not supposed to transfer R1 that way, R1 is a total body mechanical lift with two person transfer for safety. R1's first Progress Notes dated on 1/26/22 was at 7:23 PM and shows "CNA called me to patients	S9999		

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S9999	Continued From page 4	S9999		

room after dinner, patient was in bed, left ankle was bruised. There was also some swelling and some grayish/purple discoloration. Skin was warm to touch. The primary doctor and the family was made aware. Orders followed through."

R1's left ankle X-ray report dated 1/27/22 shows "there are transverse fractures evident in the distal tibia and fibula several inches above the mortise joint. Each fracture shows posterior angulation at the major apex."

R1's Care Plan dated 1/26/22 shows R1 "is alert and oriented to self, needs extensive to total assist with activities of daily living due to cognitive impairment, non ambulatory...unable to follow commands due to cognitive impairments...has limitations to both lower and upper extremities....transfer:use 2 person assist and mechanical lift. R1 is able to rarely/never understand others, she is non verbal all needs are anticipated by staff...assess for non verbal indicators of pain and discomfort....monitor for signs of restlessness or agitation."

The facility's Notice of Disciplinary Action forms shows V4 was disciplined on 2/2/22 and V5 on 2/15/22 for "Poor Job Performance Failure to observe resident safe transfer. Resident was transferred without proper equipment, failed to report to the supervisor or nurse in charge that device not in proper position for total body lift."

R1's Progress Notes does not contain any documentation on 1/25/22 or 1/26/22 prior to 7:23 PM, when R1's left ankle was found bruised and swollen.

The facility's Safe Resident Handling/Use of Mechanical Lifts Policy dated 11/31/21 shows

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S9999	Continued From page 5 "implement a Safe Resident Handling Program which establishes a framework for staff and resident safety during the handling and movement of residents...direct care staff will assess high risk resident handling task in advance to determine the safest way to accomplish them....All staff shall report to a supervisor any and all injuries or incidents involving themselves or a resident that were sustained while performing resident handling tasks." (B)	S9999		