Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED IL6000640 11/04/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9300 BALLARD ROAD LANDMARK OF DES PLAINES REHAB DES PLAINES, IL 60016 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE **DEFICIENCY**) S 000 **Initial Comments** S 000 Investigation of Faciliy Reported Incident of 10/22/22 /IL 152754 Complaint Investigation: 2298617/IL152722 S9999l Final Observations S9999 Statment 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 Attachment A plan. Adequate and properly supervised nursing Statement of Licensure Violations

H^a Think has been the control of the straight

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Illinois Department of Public Health											
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED						
		IL6000640	C 11/04/2022								
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE							
LANDMARK OF DES PLAINES REHAB 9300 BALLARD ROAD DES PLAINES, IL 60016											
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE					
\$9999	Continued From pa	ge 1	S9999		in = 54						
	care and personal or resident to meet the care needs of the re	care shall be provided to each e total nursing and personal esident.	i.	200 W		\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\					
	Nursing and Person d) Pursuant to subs	section (a), general nursing at a minimum, the following		(W) (E)							
	seven-day-a-week 6)All necessary pre assure that the resi as free of accident nursing personnels	basis: cautions shall be taken to dents' environment remains hazards as possible. All shall evaluate residents to see receives adequate supervision		ii =		in in					
	8										
73	These regulations v	were not met as evidenced by:	50			v.					
	review the facility fa safely transferred u to 1 of 3 residents (ion, interview and record niled to ensure a resident was sing a mechanical lift device (R1) reviewed for safe nple of 12. This failure resulted acture to R1.			: E(**	1 to the second of the second					
1.	The findings include	9 :	N 9		3						
# 154	11/4/22 show R1 ha	lical record accessed on as diagnoses that include failure with trach, morbid as.			-						
)H	has no cognitive im	ment dated 9/2/22 show R1 pairment. The same R1 is dependent to 2 staff for		# # # # # # # # # # # # # # # # # # #							

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING IL6000640 11/04/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9300 BALLARD ROAD LANDMARK OF DES PLAINES REHAB DES PLAINES, IL 60016 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE **DEFICIENCY**) S9999 Continued From page 2 S9999 mechanical lift transfers. R1's Facility Reported Incident (FRI) dated 10/22/22 (incident happened 10/21/22) reported to the state agency on 10/22/22 as final report show, Resident was being transferred to her chair from her bed when the mechanical lift slightly tilted in the direction of the chair, touching residents face. Nurse practitioner conducted a head-to-toe assessment and resident indicated that she had some shoulder pain. R1 was transferred to hospital and was diagnosed with closed fracture right scapula. R1's radiology report dated 10/21/22 show, "Three view of radiographic evaluation of the right shoulder. Final Result: Inferior scapular fracture. R1's Emergency Department (ED) Notes dated 10/21/22 show that R1 is a 63 y/o with diagnoses that include atrial fib on Eliquis, diabetes, chronic hypoxic respiratory failure on trach collar at 3 liters presenting to the emergency room. "she was being transferred from bed to an armchair at her nursing facility she was already in the chair when the [mechanical lift] tipped and fell into her. She endorses a mechanical lift hit her head, right shoulder and landed on her abdomen. The same notes show that "given her scapular fracture patient encouraged to have CT scan of the abdomen as well as head, however she declines. Main reason to pursue these tests (CT scan) was because patient is on Eliquis (anticoagulant)." The same ED notes show for R1 to be referred to an Orthopedic MD. On 11/4/22 at 9:13 AM, R1 was alert in bed with her trach intact. R1 said when the incident happened, the 2 (Certified Nursing

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ C IL6000640 B. WING 11/04/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9300 BALLARD ROAD LANDMARK OF DES PLAINES REHAB DES PLAINES, IL 60016 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 3 S9999 Assistant-CNA) were transferring her from the bed chair to her wheelchair. R1 said there were 2 CNAs- male and female. R1 said the male CNA was busy in his phone during the care and transfer. The female CNA was the one controlling the mechanical lift. R1 said as she was suspended in the air and was being lowered down to her wheelchair, R1 informed the 2 CNAs that she was tilted sideways and need to be positioned well. R1 said then the whole lift tipped over her and the bar (where the mechanical slings were attached) hit her face and right shoulder. R1 said she was sent to the hospital and was told she fractured her right shoulder. R1 said she always had pain n that shoulder but after the incident, the pain had gotten worst. R1 said when she moves her arm over head or when she tries to comb her hair, her pain was at a 6 (0 no pain, 10 worst pain). R1 said she was waiting for his Orthopedic appointment to be scheduled. On 11/4/22 at 9:20 AM, V8 (Registered Nurse-RN) said on 10/21/22 she was called to R1's room. V8 said R1 was sitting in her wheelchair complaining of right shoulder pain. V8 (RN) said R1 was being transferred by the 2 agency CNA (V6 and V7) using a mechanical lift. The mechanical lift tipped over hitting the right side of R1's face and right shoulder. V8 said R1 complained of pain to her right shoulder and R1 was sent to the emergency room. R1 was diagnosed with fractured right shoulder. V8 said the 2 staff (V6 and V7) that transferred R1 on 10/21/22 were both agency CNAs. Both have not been allowed to go back to the facility. On 11/4/22 at 9:32 AM, V9 (Nursing Supervisor) said he investigated the incident on 10/21/22 involving R1 and the 2 agency CNAs (V6 and V7). V9 said the investigations show that when

2CZ611

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING IL6000640 11/04/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9300 BALLARD ROAD LANDMARK OF DES PLAINES REHAB DES PLAINES, IL 60016 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX PRĖFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) Continued From page 4 S9999 S9999 R1 was being transferred, the lift device leas were not opened wide enough. V9 said the mechanical lift device is more stable when the legs are widened preventing the device from tipping over. V9 said the 2 agency CNAs involved were not to return to the facility. V9 said since the incident, the facility staff have been re trained and reeducated how to properly operate the mechanical device. On 11/4/22 at 11:30 AM this surveyor with V10 and V11 (both Restorative Aides) observed the mechanical lift device. Both said the legs of the mechanical lift device should remain wide throughout the transfer of the resident, this ensures the lift device does not tip over and it keeps the device stable. On 11/4/22 at 12:57 AM, V2 (Director of Nursing-DON) said she also investigated the incident on 10/21/22 involving R1 and the 2 agency CNAs (V6 and V7). V2 said (V6 and V7) were operating the mechanical lift device when the incident happened. Both (V6 and V7) were not allowed to go back and work at the facility. V2 said she expected that the 2 staff should have utilized the lift device correctly and would have prevented the incident. V2 said the mechanical lift device legs should have been opened wide enough to provide balance and stability to the mechanical lift. V2 said she was looking into R1's orthopedic referral at this time. The facility policy entitled Policy and Procedure for Mechanical Lift Transfer Usage show, 3. Widen the legs of the Mechanical Lift using the shift handle located in the back. Widening the leas is essential in order to get a stable base under the mechanical lift.

Illinois Department of Public HealthFORM APPROVED											
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING				(X3) DATE SURVEY COMPLETED C			
										NAME OF	PROVIDER OR SUPPLIER
LANDMARK OF DES PLAINES REHAB 9300 BALLARD ROAD DES PLAINES, IL 60016											
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROV (EACH C	IDER'S PLAN ORRECTIVE FERENCED DEFICI	LD BE COMPLETE				
S9999	Continued From pa	ge 5		\$9999							
ä	(B)						•				
100	21										
- 5											
13							- 12 - 13				
9	5				8		\$				
						1150			i		
***					101				-		
	n ⁴ .										
						=					
1000				1			5/2				
		40 00						1775			
131					:1						
					98						
				i))							
			1.		C 10						
		37	= -	5.			70		169 1		
10					•				.00		
									W		
303		769			* 2	#8	5.75				
			, a						178		
	8							17			
								\$2			
					iĝ.			i i i			
									83		
					-45						
		95			170						
lingia Danna	mont of Dublic Health										