Illinois Department of Public Health

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 ______	02/14/2023

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

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S 000	Initial Comments Annual Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 4) 330.1520b) Section 330.1520b) Administration of Medication b) No person shall be admitted to a facility who is not capable of taking his or her own medications and any needed biologicals, as approved in writing by the resident's personal physician. Facility staff may remind residents when to take medications and watch to ensure that they follow the directions on the container. This REQUIREMENT was not met as evidenced by: Based on observation, interview and record review the facility failed to ensure a resident took their scheduled medications at the ordered time for 1 of 4 residents (R107) reviewed for medication administration in the sample of 7. The findings include: R107's Physician's Order Sheet printed on 2/14/23 shows a diagnosis of diabetes mellitus and an order for, "glimepiride 2 milligrams-Give 1 tablet by mouth one time a day for DM (Diabetes Mellitus) give before breakfast." On 2/14/23 at 9:40 AM, V6 (Certified Nursing Assistant) said that breakfast arrives between 7:30-7:45 AM and all the residents have already	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 eaten breakfast. On 2/14/23 at 9:45 AM, V7 (Licensed Practical Nurse) administered R107's glimepiride. On 2/14/23 at 10:42 AM, V3 (Assistant Director of Nursing) said that if a medication is ordered before breakfast, it should be given before breakfast. The facility's Physician Orders Policy revised on 7/28/22 shows, "It is the policy of this facility to ensure that all resident/patient medications, treatment and plan of care must be in accordance to the licensed physician's orders. The facility shall ensure to follow physician orders as it is written in the POS (Physician's Order Sheet). (C) Statement of Licensure Violations (2 of 4) 330.710c)3)A)	S9999		
	Section 330.710c)3)A) Resident Care Policies			
	c) The written policies shall include, but are not limited to, the following provisions: 3) A policy to identify, assess, and develop strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a resident. The policy shall establish a process that, at a minimum, includes all of the following: A) Analysis of the risk of injury to residents and nurses and other health care workers, taking into account the resident handling needs of the			

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resident populations served by the facility and the physical environment in which the resident handling and movement occurs.

This REQUIREMENT was not met as evidenced by:

Based on observation, interview, and record review the facility failed to follow their policy by not ensuring a resident with a history of falls was assessed for risk for falls for 1 of 4 residents (R102) reviewed for falls in the sample of 7.

The findings include:

On 2/14/23 at 9:25 AM, R102 was sitting in her wheelchair at the dining room table eating breakfast. R102 had a chair alarm pad on the seat of her wheelchair with the cord wound around the back of the wheelchair. The chair pad alarm cord did not have an alarm connected to it.

On 2/14/22 at 9:42 AM, R102 was in bed and stated, "I feel weak and nauseated today."

On 2/14/22 at 10:50 AM, R102 transferred herself from her wheelchair to the toilet without staff. R102 was standing up and wiping herself and then sitting back down on the toilet. At 10:54 AM, V7 Licensed Practical Nurse walked down the hallway and saw R102 on the toilet. R102 stated to V7 "I feel ill. I feel weak." V7 helped R102 transfer back into the wheelchair with stand by assist.

On 2/14/22 at 10:55 AM, V8 Certified Nursing Assistant stated "R102 used to have a fall alarm a few months ago not now. She can get out of balance so we keep an eye on her, she is 97 years old, and anything can change."

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S9999	Continued From page 3 On 2/14/22 at 10:58 AM, V7 stated R102 is confused today." On 2/14/22 at 11:50 AM. V3 Assistant Director of Nursing said fall assessments should be done on admission, after a new fall, and every 6 months. On 2/14/22 at 12:15 PM, V9 Restorative Nurse said she is not familiar with R102 and has not assessed her. V9 said fall risk assessments should be done every 6 months. V7 said R102 had a fall in 4/2022 and had physical therapy at that time, but no therapy since. V7 said she had not seen the physicians progress note dated 12/18/22 and that R102 should have a fall assessment done now. R102's most recent fall assessment was dated 7/6/22 (7 months ago). R102's Physician Progress Note dated 12/19/22 shows "Assessment and Plan ...3. Falling, unstable gait, continue Physical Therapy, falls prevention. R102's Transferring task for the last 30 days shows R102 at times has needed limited assistance where staff provide guided maneuvering of limbs or other non-weight bearing assistance and extensive assistance where staff provide weight-bearing support. R102's Care Plan dated 4/27/22 shows "I am at high risk for falls related to polyneuropathy, difficulty walking, lack of coordination, unsteadiness on feet, spondylosis, Raynaud's syndrome, poor safety awareness ....I have periods of forgetfulness. I would like staff to frequently orient me to my surrounding."	S9999		

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The facility's Fall Occurrence Policy dated 7/17/22 shows "a fall risk assessment form will be completed by the nurse or the falls coordinator upon admission, readmission, quarterly, significant change, and annually ....If a resident had fallen the resident is automatically considered as high risk for falls."

(C)

Statement of Licensure Violations (3 of 4)

330.710a)
330.710c)3)F)
330.4210a)

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.

c) The written policies shall include, but are not limited to, the following provisions:

3) A policy to identify, assess, and develop strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a resident. The policy shall establish a process that, at a minimum, includes all of the following:

F) Development of strategies to control risk

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of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a resident.

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)

These REQUIREMENTS are not met as evidenced by:

Based on observation, interview and record review the facility failed to ensure a dementia resident (R100), who was at risk for falls, was supervised by staff, while in the activity room. This failure contributed to R100 sustaining a fall which resulted in a right arm fracture. The facility failed to ensure a resident (R101) was transferred in a safe manner. These failures apply to 2 of 4 residents reviewed for safety and supervision in the sample of 7.

The findings include:

1. R100's Admission Record printed February 14, 2023 showed R100 was admitted to the facility on October 27, 2022 with diagnoses including dementia, lack of coordination, and abnormalities of gait and mobility.
R100's Admission Assessment/Baseline Careplan dated October 27, 2022 showed R100 was at risk for falls due to poor safety awareness, unsteady gait, and disease process (dementia).

R100's Incident Report dated December 16, 2022

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S9999	Continued From page 6 showed R100 sustained an unwitnessed fall in the activity area/living area of the facility. The report showed R100 was found on the floor by staff. R100 complained of pain to his right arm. R100 was emergently sent to a local hospital for evaluation and diagnosed with a right humerus (arm) fracture. On February 14, 2023 at 9:16 AM, R100 was seated in a wheelchair in the dining room. A cloth arm sling was noted to R100's right arm. V6 Certified Nursing Assistant (CNA) was seated in the dining room, by R100. V6 stated, "(R100) was in the television lounge, in a group activity, when he fell. A call light was going off, so I left to go answer it. I heard (R100's) chair alarm go off. When I got back to the lounge, I found him on the floor, in front of his wheelchair. He tried to self-transfer. No staff were in the lounge when (R100) fell. We are not supposed to leave residents alone in the activity room but I had to answer a call light." On February 14, 2023 at 12:25 PM, V9 Restorative Nurse stated, "(R100) is confused related to his dementia. He is impulsive. He tries to stand up on his own. He has poor safety awareness. He needs a lot of reminders to call for help. During the day, we try to keep him out in the common areas so we can watch him because he is so impulsive." On February 14, 2023 at 10:35 AM, V3 Assistant Director of Nursing (ADON) stated, "Our sheltered care residents shouldn't be left alone in the dining room or activity rooms. Staff should be supervising them for safety reasons." The facility's Fall Prevention Program Guidelines policy dated August 5, 2022 showed, "Fall	S9999		

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prevention program guidelines shall be implemented to promote safety of all residents in the facility ... All assigned nursing personnel and facility staff shall be responsible for ensuring ongoing precautions are put into place and consistently maintained ...Fall interventions shall include staff, family and resident education, programs, purchase of equipment or other environmental-related alternatives to prevent the resident from falling ...Consider placing confused resident or difficult to redirect resident by the nurses' station or within eye contact ..."

2. R101's Service Plan dated June 18, 2022 showed R101 was at risk for falls related to her lack of coordination, memory impairment, and unsteady gait.
R101's Toileting Task Records dated January 16, 2023-February 14, 2023 showed R101 required, at minimum, limited assistance of one staff for toileting.

On February 14, 2023 at 9:32 AM, V6 CNA transferred R101, on and off the toilet, without the use of a gait belt. V6 CNA held onto the waistband of R101's pants to assist with the transfers.

On February 14, 2023 at 10:35 AM, V3 ADON stated, "Gait belts should be used to assist residents with transferring unless a resident is completely independent."

The facility's Gait Belt policy dated July 28, 2022 showed, "Staff will use a gait/transfer belt on residents who need limited to total assistance with transfers or walking ..."

(B)

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S9999	Continued From page 8 Statement of Licensure Violations (4 of 4) 330.2000 Section 330.2000 Food Handling Sanitation Every facility shall comply with the Department's rules entitled "Food Service Sanitation" (77 Ill. Adm. Code 700). This REQUIREMENT was not met as evidenced by: Based on observation interview and record review the facility failed to ensure personal room refrigerator temperature containing residents' foods was monitored to 2 of 2 residents (R106, R102,) reviewed for food sanitation in the sample of 7. The findings include: On 2/14/23 at 10 AM, R106 has a room refrigerator (fridge). The fridge had fruits, mayo and cheese. There was no thermometer inside the fridge and no log for temperature monitoring. At 11:02 am, R102's has a refrigerator in the room. The fridge was full of drinks, food and had ice cream in the freezer. The fridge had no thermometer and there was no log for temperature monitoring. On 2/14/23 at 10:10 AM, V4 Maintenance Director said room refrigerator temperature should be monitored daily by the nursing staff. On 2/14/23 at 2:05 PM, V1 (Administrator) said room refrigerator temperature should be monitored daily to ensure food in the fridge won't be spoiled. V1 said she had in serviced staff and	S9999		

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S9999	Continued From page 9 will now monitor room fridge temperature daily. The facility policy entitled Food Temperature Maintenance dated 7/28/22 show, It is the policy of this facility to ensure that food items shall be served to the resident at an appropriate temperature ...2. To reduce food borne illness. 4. Refrigerator temperature should be maintained at 36-44 degrees Fahrenheit. (AW)	S9999		