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
	IL6013213	A. BUILDING: ______ B. WING ______	C 03/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLNWOOD PLACE	7000 NORTH MCCORMICK BLVD. LINCOLNWOOD, IL 60645

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S 000	Initial Comments Facility Reported Incident of 2/14/23/IL157230	S 000		
S9999	Final Observations Statement of Licensue Violations 300.610a) 300.1210b) 300.1210c) 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 plan. Adequate and properly supervised nursing	S9999	Attachment A Statement of Licensure Violations	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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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 and assistance to prevent accidents.

These requirements were not met as evidenced by:

Based on observation, interview, and record review the facility failed to implement R1's care plan in providing assistance in transferring resident from bed to wheelchair and failed to follow its policy in transferring resident (R1). This failure caused a laceration of R1's right lower leg that required treatment at hospital of 18 staples to control bleeding. The facility failed to update R1's care plan after the laceration injury during transfer. The facility also failed to implement its fall prevention care plan, complete fall accurate assessment and update the fall care plan based on post fall investigation to prevent future falls. This deficiency affects all three (R1, R2 and R3) residents reviewed for Resident safety.

Findings include:

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1. R1 is admitted on 7/19/22 with diagnosis listed in part but not limited to Spinal stenosis lumbar region with neurogenic claudication, Peripheral vascular disease, Chronic venous insufficiency, Diabetes Mellitus type 2, Congestive heart failure, Bilateral hearing loss. MDS (Minimal Data Set) /Resident assessment Section G Functional status G0110 Activity of Daily Living (ADL) assistance B. Transfer indicated: Self performance: Extensive assistance; Support: Two + persons physical assist. Care plan indicated: He has ADL self-care performance deficit related to weakness, decrease mobility, osteoarthritis, heart failure, obesity. He needs extensive assistance with 2 assists with transfer. He always utilizes wheelchair. Intervention: Transfer: he requires extensive assistance by 2 staff to move between surfaces. R1 has potential for an alteration in skin integrity. Intervention: Use caution during transfer and bed mobility to prevent striking arms, legs and hands against any sharp or hard surface. R1's care plan is not updated after laceration injury during transfer.

R1's post incident investigation report completed by V3 RN indicated on 2/14/23 at 7:20am, V5 Agency CNA transferred R1 from bed to wheelchair after putting R1 to the wheelchair, CNA observed R1's right leg with laceration with bleeding. R1 stated that his right leg was caught on the wheelchair. Immediate staff intervention: ordered new wheelchair for R1.

R1's incident report submitted to IDPH dated 2/15/23 indicated: On 2/14/23, V5 CNA transferring R1 from bed to wheelchair. Once in the wheelchair, V5 noticed right lower leg bleeding. V5 immediately called V3 RN to assess

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S9999	Continued From page 3 the laceration. V3 applied pressure dressing to control the bleeding. Physician notified and ordered to send R1 to the hospital for evaluation but R1 refused when paramedics arrived. R1 was educated by V3 on the importance of going to hospital to get leg looked at and treated. Laceration was monitored throughout the day and R1 was repeatedly encourage by staff to go to hospital. R1 finally agreed to be sent out to hospital. Physician and family made aware. Conclusion: R1 is alert and oriented x 3 and able to verbalize needs. R1 requires extensive assistance of 1-2 staff to move surfaces. When interviewed, R1 stated that while transferring from his bed into his wheelchair with V5 CNA, R1 obtained skin tear from the frame of his wheelchair. R1 originally refused to go to hospital but after repeated education and encouragement from nursing staff, R1 was agreeable. R1 was sent out to the hospital and received 18 staples in his leg and started on antibiotics prophylaxis to prevent infection. R1 returned to the facility and foam covering was placed on the identified area of the wheelchair. New wheelchair has been ordered for the resident. Physician and family updated. Facility continues to monitor skin laceration and follow treatment as ordered. Final incident report was submitted to IDPH on 2/16/23. R1's hospital record dated 2/14/23 indicated: An 82-year-old male, presented with chief complaint of laceration (right leg) that occurred while transferring between his wheelchair at the nursing home. Impression/plan as follows: 10 cm laceration. 18 staples placed. Return in 10-14 days. Return precaution including infection, bleeding. On 3/14/23 at 10:11am, Observed R1 sitting in front of his desk top computer. He is alert and	S9999		

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oriented x3 but hard of hearing. He speaks softly and slow. Surveyor communicates with R1 using handwritten notes due to hard of hearing. R1 said that V5 CNA was transferring him to his wheelchair from bed when something sharp from his wheelchair caught his right leg. V5 held him using his hands when transferring him to bed. V5 did not use gait belt. He transferred him by himself. Observed R1's right leg with steri- strips, swollen with discoloration. Called V3 RN to R1's room.

On 3/14/23 at 10:28am, V3 RN said that she is the nurse working when R1 has laceration incident on his right leg. She said that V5 CNA reported to her that R1 is bleeding from his right leg after he transferred him from bed to wheelchair. V5 did not know what happened. V3 said that his right leg probably caught from sharp bolts protruding from his wheelchair's leg/footrest. She said that they discarded the old wheelchair and got her a new one. R1 currently does not have leg/footrest attached to his wheelchair. She said that R1 needs 2 persons assist for transfer. R1 has diagnosis of PVD that is why she has discoloration and swelling of both legs. She said that V2 removed the sutures 10 days after the incident happened and applied steri-strips and keep it open to air.

On 3/14/23 at 10:38am, V3 RN said that they don't have list of residents on high risk for falls/ fall precaution monitoring or resident who has recent injury. She said they communicate with 24 endorsement/report written each shift. Rounds made with V3 RN.

2. On 3/14/23 at 10:41am, Observed R2 lying in bed. Call light within reach. Her bed is on high

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position (approximately 27 inches from the floor) and the control of the bed is at the foot part of the bed. V3 RN said that R2 is just admitted yesterday with diagnosis of fracture of right leg from falling. V3 said that bed should be in lowest position for safety, but she has to check the care plan. V3 did not adjust the bed to the lowest position.

R2 is admitted on 3/13/23 with diagnosis listed in part but not limited to Fracture of right lower leg, Syncope and collapse, History of falling, Hypertension. Admission fall assessment dated 3/13/23 indicated: low risk for falls. Care plan indicated: R2 is at high risk for falls related to deconditioning, history of falls, syncope, use of antihypertensive, psychotropic medications.

On 3/14/23 at 10:44am, V4 Agency LPN said that she does not know who are the residents on her side on fall precautions or has recent injury. She did not receive report from the night nurse.

On 3/14/23 at 10:52am, Review medical records of R2 with V3 RN. R2's admission fall assessment indicated low risk for fall. R2 is admitted with fracture right leg from fall. Her care plan indicated she is at high risk of fall.

Review 24 hours endorsement report received by V3 RN from night shift that R1 and R2 are not in fall precautions or history of injury. R3 indicated high risk for fall.

3. R3 is admitted on 12/2/22 with diagnosis listed in part but not limited to Fracture of lower end of femur, Dementia with mood disturbance, History of falling, Macular degeneration, Presence of artificial right hip joint, Peripheral vascular

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S9999	Continued From page 6 disease. R3's care plan indicated she is at high risk for falls. Intervention: Follow facility's fall protocol. R3 had witnessed fall incident during transfer dated 12/12/22. Post investigation new interventions: Bed low position, Call light within reach, Continue PT for strength and mobility and use of gait belt while transferring. R3's fall care plan was not updated based on post fall investigation, Bed low position and use of gait belt while transferring were not written as interventions. On 3/14/23 at 11:08am, Observed R3 lying in bed in high position, bed control is at the foot part of the bed. V3 RN took the bed control and placed the bed in the lowest position. On 3/14/23 at 11:31am, V2 DON said that she is the also the Fall coordinator. V2 said that they have fall prevention program which included all residents on high risk for fall and those who has history of falls. They don't have binder or list of residents on fall prevention program. Residents on fall precautions should be indicated in the shift to shift 24 reports. Fall assessment is done upon admissions, quarterly and after each fall incidents. Asked DON how much assistance R1 needs for transfer. V1 said R1 needs 2 persons assist. Informed V1 that R1 was transferred by V5 CNA by himself instead of 2 persons assist, then she said R1 can be transferred 1-2 persons assist. V2 said that she did not remove R1's right leg staples, V8 LPN did on 2/24/23. On 3/14/23 at 12:27pm, V6 Executive Director presented policy on Safe resident handling and movement. V6 said that Safety transfer of resident is determined by licensed professionals and as indicated in MDS.	S9999		

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S9999	Continued From page 7 On 3/14/23 at 12:46pm, V7 Physical Therapy said that he has taken care of R1 last year when R1 was on Therapy services. R1 was discharged from therapy with 2 persons assist for transfer. V7 said that the wheelchair's leg/foot rest should be removed so it will not be in the way when transferring resident from bed to wheelchair. The legs may be caught during the transfer. V7 added that the wheelchair should be in 45-degree angle to the bed and the leg/footrest sticking out will not ensure the wheelchair is close to bed, so its recommended to take it off. V7 said that they don't provide CNA training for transferring resident from bed to wheelchair/wheelchair to bed, it's the nursing department who provides training to CNAs and nurses. On 3/14/23 at 1:10pm, V2 DON said that CNA should use gait belt when transferring resident from bed to wheelchair. The floor nurse should give report to the agency CNA regarding assistance in resident's transfer. R1 needs 1-2 persons assist in transferring from bed to wheelchair. Informed V2 of the following concerns identified after interviewing with R1, V3 RN and V7 PT. R1 was transferred by V5 CNA by himself without using gait belt. V5 CNA did not remove R1's wheelchair leg/footrest prior to transferring him from bed to wheelchair. Per V3 RN and V7 PT, R1 is 2 persons assist for transfer. R1's MDS/Resident assessment and care plan indicates that he is 2 persons assist for transfer. R1 and V3 RN said that R1's right leg is caught from the sharp objects from his wheelchair leg/footrest causing laceration on right leg that needed treatment from the hospital. V2 said that outside therapy company did transfer in-service to CNAs and nurses last Dec 2021. V2 denied that R1's right leg was caught from the leg rest. V2 said it caught from of the wheelchair's frame	S9999		

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near the arm rest. Surveyor requested to see R1's old wheelchair. At 1:56pm, V2 said that R1's old wheelchair was thrown away already.

On 3/14/23 at 2:51pm, Review R1, R2 and R3 medical records with V2 DON. Showed to V2 R1's MDS/Resident assessment and care plan indicating 2 persons assist for transfer. V2 said that after resident's fall incident IDT (Interdisciplinary team) will do the root cause analysis and formulate new care plan intervention to prevent future falls. IDT includes V2 DON, Care plan coordinator, Social Service, and floor nurse at times. Post fall investigation is completed by the floor nurse on Section A and V2 DON on Section B. Care plan updated by V9 Care plan coordinator. Post care plan investigation and care plan update for any incident is done within 24 to 72 hours. Informed V2 of observation during rounds made with V3 RN. Both R2 and R3's beds are on high position. R2's fall admission assessment indicated she is at low fall risk despite that she is admitted with fracture of right leg due to fall. R1 and R3's care plans were not updated based on post injury/fall investigation. V2 said that She does the post fall investigation/root cause analysis with new fall interventions and V9 does update the care plan.

On 3/14/23 and 3/15/23, Attempted to call V5 CNA several times left message but did not call back. V2 DON aware.

On 3/15/23 at 11:35am, Informed V2 DON of inconsistency of incident documentation of incident in regards with their policy. Per V3 and V2 DON, any incident report is not documented in resident's progress notes. It was documented in paper form of post investigation report, fall follow up assessment and change of clinical condition

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assessment. But facility's policy indicates: Incident documentation is documented in resident's progress notes.

On 3/15/23 at 11:59am, V10 Maintenance Supervisor said that he has been working in the facility for 9 years. He said that they check for wheelchair safety weekly such as brakes, hand rest and leg rest. The one responsible for checking this is V11 Director of Plant Operation but he was let go last month. V10 said that he cannot find the log documentation that R1's wheelchair was checked for safety. V10 said that he recently took over this month because he was on vacation last month. He said that they don't repair wheelchair because it does not cover by insurance, they disposed it.

Facility's policy on Safe resident handling and movement indicates: These guidelines are developed to assist staff when performing resident transfers, including manual transfer and transfer using assistive device and assisting residents with mobility. The procedures within these guidelines, as well as any other policies and procedures for resident care and services, must be followed whenever an employee provides assistance to residents with transferring and movements.
Procedure: All residents are evaluated according to evaluation policy and procedure guidelines. The determination of the resident's transfer/movement ability will be determined by a licensed professional such as but not limited to : RN, PT, OT, MD, LPN/LVN.
All staff responsible for assisting with resident transfers will be observed for competency on a routine and as needed basis.

Facility's policy on Transfer belts indicates: Any

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resident who requires minimal assist or more to transfer or ambulate will utilize a transfer belt for resident and employee safety. Only transfer belts with handles should be utilized.
Procedure:
1) Resident ambulating and transfer will be determined by an evaluation by an RN/PT/OT/MS/LPN/LVN. The evaluation/assessment will determine what size transfer belt the resident will utilize. The transfer belt will be resident specific.
9)Staff to place the transfer belt around the resident's waist. The belt should fit "snuggly" but not "tight". Best practice is ensuring 2 fingers fit between belt and resident's body. Staff should place hands in transfer belt and handles and not between and resident's body.
11) If a resident needs assistance of 2 caregivers, staff are to follow the procedure for the one caregiver transfer with the second caregiver on the side/back of the resident. Staff to stand with a broad base of support, with feet shoulder width apart. Staff to place hands in transfer belt handles. Resident should move as close to the edge of the bed/chair as safety allows. Staff to ensure all applicable wheel locks are locked.

Facility's policy on fall program- Skilled indicates: The community will have a system in place to ensure that the community's residents are assessed on admission for their potential fall risk and to guide in the implementation of interventions to assist in decreasing the frequency or severity in the event a fall does occur.
Proper actions following fall include:
*Revising the resident's plan care and/or community practices, as needed, to reduce the likelihood of another fall
Supervision- The community is obligated to

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S9999	Continued From page 11 provide adequate supervision to prevent accidents. Adequacy of supervision is defined by type and frequency, based on the individual resident's assessed needs and identified hazards in the resident environment. Facility's policy on Fall management program guidelines indicates: Senior lifestyle is committed to minimizing resident falls and or injury and to maximizing each resident's physical, mental, and psychosocial well-being. While preventing all resident falls is not possible, the community will act in a proactive manner to identify and assess those residents who are at risk for falls, plan for preventive strategies and facilitate a safe environment. Procedure: 1. All staff will be responsible in assisting with the implementation of the community's Fall management program to maintain the safety of all residents in the community. The program will include measures which determine the individual needs of each resident by evaluating the risk for falls and implementation of appropriate interventions to provide necessary supervision and assistive devices as necessary. Fall management program standards: 2. If a resident has a fall or continues to have falls, the Care plan will be updated with new interventions after each fall. Immediately following fall, the fall temporary service plans should be initiated by staff. Upon investigation completion, DON or designee will resolve the fall temporary service plan and update the current care plan with on-going interventions to reduce falls. 3. The goal is to identify interventions to reduce the number of falls and prevent serious injury from falls. 4. Current interventions and any new	S9999		

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S9999	Continued From page 12 interventions added will be discussed with care staff to ensure full understanding. 6. All staff will be trained on the fall prevention program. Facility's policy on Documentation guidelines indicates: Approved staff will document concise and factual information regarding resident's care and condition. Incident Documentation: 1. DON/designee to complete progress notes for all resident incidents. 3. Monitor and document in progress notes a minimum of once daily for 72 hours. (B)	S9999		