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 10/01/2024

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 Investigation 8.27.24/IL178243	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 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 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	S9999		

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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 evidence by:

Based on interview and record review, the facility failed to maintain resident safety during a mechanical lift transfer, failed to ensure the mechanical lift sling was correctly applied during transfers, and failed to use a two person assist during a mechanical lift transfer. This affected one resident (R1) of three residents reviewed for safety and mechanical lift transfer. This failure resulted in R1 sliding from mechanical lift sling, sustaining a 3cm (centimeter) laceration to the posterior scalp, being sent to the local hospital where 3 staples were required to close the laceration.

Findings Include:

Facility reported incident with date of occurrence of 8/27/24, reads in part: R1 had a witnessed fall during transfer from bed to wheelchair and was sent to ER (Emergency Room) for further evaluation. (R1) returned to facility with all diagnostic test negative for injury but required 3 stapled to back of head. Conclusion: on 8/27/24 at 1005, (R1) had a witnessed fall from mechanical lift. (R1) was placed into mechanical

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lift with sling, Agency CNA (Certified Nursing Assistant) was moving (R1) from bed towards wheelchair via mechanical lift when (R1) slid from mechanical lift sling. (V2 Director of Nursing/DON) called to the scene immediately and recognized that agency CNA incorrectly applied the sling to the lift. 911 (emergency response) was called, (R1) was sent to ER for evaluation, returned to facility with 3 staples to back of head. No other injuries identified.

Hospital record dated 8/27/24, reads in part: (R1) status post fall at Nursing home, States the staff was moving her in her lift when she fell backward striking her head. (R1) had 3 cm laceration to posterior scalp. 3 cm in length and 2 mm (millimeter) in depth. Repaired with 3 staples.

On 10/1/24 at 10AM, V2 (DON) stated that the incident was reported by V8 (CNA). V8 reported to V2 that there was a fall, and that V8 was observed to be visibly upset when V8 came to V2's office. V7 (Agency CNA) was transferring R1 and had a fall. V2 went to check on R1, R1 was on the floor, R1's head was resting on a towel but R1's head was closer to the metal leg based part the mechanical lift machine. V7 told V2 that R1 slid out of the sling. V2 observed the sling was still attached to the mechanical lift. It was apparent that V7 did not correctly attach and applied the divided leg sling to the resident and mechanical lift machine. The leg straps are supposed to crisscross and that is what would prevent the resident from sliding out of the sling. V7 used it as a chair sitting position, and straps did not go to a loop to prevent the resident from sliding out. V7 admitted V7 was doing the transfer by herself. V2 stated that V7 reported to

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her that at first, V7 asked for help and V8 came in the room and turned around and left. V2 interviewed V8 and stated that V8 was asked for help but when V8 went to R1's room, R1 was not prepared yet, not dressed or toileted, so V8 told V7 to get R1 ready and to let V8 know when V7 is ready to transfer R1. V8 left the room and assisted other resident, and when V8 walked passed the room of R1, observed R1 was on the floor and V7 was in the room. It was bad judgment and was rushed. V7 knew she needed second person for transfer. V7 made a bad decision, made the right call to ask for help at first but then did not wait and transferred R1 with one person assist. R1 had laceration on back of the head and returned in the facility with 3 staples.

Facility provided a written statement from V7 (Agency CNA), reads in part: (V7) was working with (R1), trying to get (R1) ready. Asked another CNA (V8) for help with transfer. (V8) came in the room and left. (V7) put the sling underneath (R1), (V8) walked pass the room and asked "do I have it" as (V7) was listing (R1) with the mechanical lift. (V7) was using the control to adjusting (R1) (moving her so her head did not bum the bar) while up on mechanical lift. As (V8) entered the room, is when (R1) slid from the sling. (V7) stated that (V7) was not familiar with the type of (Mechanical Lift)/sling, and asked for assistance but the person left the room and said she would be back. No response when asked if aware that (V7) need 2 person assist with mechanical lift.

Facility provided a written statement from V8 (Agency CNA), reads in part: (V8) was asked by (V7) to assist with the use of mechanical lift for

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(R1). (V8) went into the room to assist with the transfer, but (V7) did not have (R1) prepared, (R1) was not dressed or had sling underneath (R1). (V8) informed (V7) that (V8) have another resident at the toilet at the moment and will be back after (V7) has (R1) prepared for transfer. When (V8) came back about 10-15 minutes later, (V8) walk passed the room and see (V7) had (R1) in the mechanical lift. (V8) walked into the room to assist and as (V8) entered the room, (R1) just slid from the sling to the floor. (V8) went and got the nurse right away.

R1's Care Plan, revision date 5/30/24, reads in part: that (R1) requires extensive assistance with ADLs (Activities of Daily Living) due to generalized weakness. Extensive assist with two members with transferring.

Use of Mechanical Lifting Machine with a reviewed date of 2/23/24, reads in part: The purpose of this procedure is to establish the general principle of safe lifting using a mechanical lifting device. It is not a substitute for manufacturer's training instructions. At least two (2) staff member are required to safely use mechanical lift. Place the sling under the resident. Visually check the size to ensure it is not too large or too small. Attach sling straps to sling bar, according to manufacturer's instruction.

Facility provided a copy of instruction with picture observed to be attached on the mechanical lift machine, reads in part: Mechanical lift, 2 person assist. Place sling under resident. Take bottom straps and place under each leg. Connect the bottom straps to the bottom part of the lift. Connect the side straps to the middle part of the

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S9999	Continued From page 5 lift. Connect the top straps to the top of the list. Place resident arms on their chest. The colors on straps should match all the way around. Any questions should be addressed to CNA, Nurse, ADON (Assistant Director of Nursing) and DON before starting the transfer. (B)	S9999		