

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145739	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2025
NAME OF PROVIDER OR SUPPLIER Lutheran Home for the Aged		STREET ADDRESS, CITY, STATE, ZIP CODE 800 West Oakton Street Arlington Hts, IL 60004	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on interview and record review the facility failed to ensure a resident was safely transferred using a mechanical sit to stand lift for 1 of 3 residents (R1) reviewed for safety in the sample of 3. This failure resulted in R1 being assisted to the ground and sustaining a proximal tibia and fibula fracture of her right leg.</p> <p>The findings include:</p> <p>R1's Nursing Notes dated 6/28/25 shows that at 1:00 PM, the Certified Nursing Assistant said that R1 passed out while providing care to R1 after having an extra large bowel movement while using a sit to stand lift and R1 was assisted to the floor with two person assist.</p> <p>R1's Right Tibia/Fibula X-ray dated 6/28/25 shows, There is a fracture involving proximal tibia and fibula (bones of the upper shin) with minimal displacement.</p> <p>On 7/2/25 at 10:12 AM, V3, Certified Nursing Assistant (CNA) said that on 6/28/25 after lunch, she was assisting R1 to use the toilet. V3 said that she placed R1 on the toilet from her wheelchair using the mechanical sit to stand lift. V3 said that once R1 was done using the bathroom, she lifted her up from the toilet with the lift and moved her to the side so she could clean her up. V3 said R1 then had another bowel movement all over herself and the floor. V3 said that as she was cleaning her up, R1 slumped over and her hands went down from holding onto the lift and would not respond to her. V3 said that she immediately started calling for V4 (CNA) and the nurse. V3 said that R1 was brought out of the bathroom and into her room area. V3 said that she tried to lower her to her wheelchair but the lift was not lowering and the emergency release button was not working as well. V3 said that V5, Registered Nurse (RN) and V6 Licensed Practical Nurse (LPN) Supervisor showed up and said to put her on the ground. V3 said that her and V4 both grabbed under R1's arms and lowered her to the ground while the nurse used the control to lower the machine. V3 stated, I guess the nurse was able to get the machine to work to be able to lower her as we were lowering her.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/2/25 at 10:34 AM, V4 (CNA) said that she was by the shower room waiting for her resident to get done going to the bathroom when V3 came to the door of R1's room and said to call the nurse. V4 said that she immediately went into R1's room and R1 was hooked up to the sit to stand lift and was located outside of the bathroom door. V4 said that R1 was unresponsive and her right leg was off of the platform of the lift and her foot was turned inward. V4 said that the leg strap was not around R1's legs. V4 said that they were not able to sit her into her wheelchair because her leg was in the way and they did not want to twist it anymore. V4 said that V3 told her that they were going to have to put her onto the floor. V4 said that she was worried about putting her onto the floor because of the way her leg was positioned. V4 stated, I was worried that putting her on the floor would break her leg based on how it was already positioned. V4 said that they proceed to slowly lower her to the floor by holding under her arms.</p> <p>On 7/2/25 at 10:51 AM, V5 (RN) said that she heard V4 yelling for help. V5 said that she went into R1's room and saw R1 hanging from the sit to stand lift and unresponsive. V5 said that she did not pay attention to the positioning of R1, she was more worried about her being unresponsive. V5 said that she immediately called V6 (LPN Supervisor) to help. V5 said that she then exited the room and went and got R1's code status and oxygen. V5 said that when she returned, R1 was on the floor. V5 said that she did an assessment and found R1 to have a bruise with an abrasion on her right shin area.</p> <p>On 7/2/25 at 11:08 AM, V6 said that V5 called her while she was on the elevator. V6 said that she immediately went to R1's room and saw R1 still harnessed into the sit to stand lift. V6 said that R1 was unresponsive, her left arm was hanging down and her right arm was elevated above her head due to the harness slipping up and pushing her arm up. V6 said that she tried to put the wheelchair under her but she had slipped down too far so was unable to get the wheelchair under her. V6 said that they then lowered her to the ground. V6 said that during the transfer, her right leg was bent and turned but they were unable to straighten it so when she was lowered to the ground, her right lower leg was bent and under her.</p> <p>On 7/2/25 at 11:40 AM, V3 said that when R1 was taken out of the bathroom, her right leg came off of the platform. V3 said that the leg strap was on but it was loose. V3 said that she removed the strap to try and get R1's right leg back onto the platform but she was unable to.</p> <p>On 7/2/25 at 11:49 AM, V4 said that when they got R1's bottom to the floor, her left leg was straight out and her right lower leg was under her and to the side. V4 said that V3 moved her leg to a straight position and then they laid her flat on the floor.</p> <p>On 7/2/25 at 1:27 PM, V9 (R1's Physician) said that she saw R1 immediately after the fall. V9 said that R1 had some bruising and swelling of her lower leg right below her knee which is where the fracture was found. V9 said that R1's leg must have twisted during the fall. V9 said that the fracture is directly related to the fall.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/2/25 at 1:45 PM, V8 (Restorative Aide) said that residents should be secured appropriately in the sit to stand lift before performing any transfers. V8 said that a harness is applied to the torso and secured with a strap. The strap should be snug. V8 said that the feet should be placed flat on the platform and their knees should be up against the knee pad. V8 said that once the resident's legs are in proper position, the leg strap should be applied snugly. V8 said that the resident should be lifted a little bit and the torso harness strap should be tightened more. V8 said that resident's should only be moved short distances with the sit to stand lift. V8 said that if a resident becomes unresponsive during a transfer, the staff should immediately lower the resident back to a seated position on whatever surface is closest to the resident. V8 said that if a resident is secured correctly on the sit to stand lift, the torso should not be able to slip from the harness and the feet would not be able to fall off of the platform. V8 said that it could be very dangerous if a resident was transferred with a sit to stand lift and not secured appropriately.</p> <p>On 7/2/25 at 2:22 PM, V2 (Director of Nursing) said that when using a sit to stand lift, the resident should have the harness strap secured tightly around their waist and should have the leg strap secured tightly around their lower legs. V2 said that if the leg strap is on securely, a resident's foot would not be able to come off of the platform.</p> <p>The facility's Mechanical Lift Policy dated 5/23/24 shows, The purpose of this policy is to establish the general principles and procedure of safe lifting using mechanical lifting devices Position the top of the harness around the upper body of the resident (approximately 4-5 inches below the underarm). Securely fasten the harness safety strap around the resident's chest . Position the unit in front of the resident and have the resident place their feet on the foot plate and position their shins into the shin pad Secure the shin straps around the resident legs .</p>		