

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145786	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/01/2024
NAME OF PROVIDER OR SUPPLIER Lincolnwood Place		STREET ADDRESS, CITY, STATE, ZIP CODE 7000 North McCormick Blvd. Lincolnwood, IL 60645	
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>41156</p> <p>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.</p> <p>Findings Include:</p> <p>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 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.</p> <p>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.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 145786	If continuation sheet Page 1 of 3

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>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 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.</p> <p>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.</p> <p>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 (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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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 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.		