STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146061	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookdale Plaza Lisle Snf	1800 Robin Lane Lisle, IL 60532

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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident was transferred safely with a mechanical lift.This applies to 1 resident (R1) reviewed for safety in a sample of 3. The past non-compliance occurred between 7/10/2025 and 7/18/2025.The findings include:R1's face-sheet showed R1 was a [AGE] years old female admitted with diagnoses to include congestive heart failure, dementia, anxiety, depression, hypertension, osteoporosis, intervertebral disc degeneration, urinary infection, sepsis and encephalopathy. R1's MDS (Minimum Data Set) on 7/11/25 showed severe cognitive impairment. R1's Progress notes, dated 7/11/25 at 8:15 AM, showed right sided bruising noted by CNA while giving bed bath. RN assessed R1 and found dark purple bruising on right side ribs, hip, knee and foot. The final Facility Reported Incident (FRI) received on 7/18/25 at 12:00 PM showed, On July 11, 2025, (R1) was observed by a Certified Nurse Assistant (CNA) with discoloration on the right ribs, right hip, right knee and right ankle area. The areas were evaluated and observed to be dark purple with a yellow hue, the skin was intact, warm, and dry to touch. Measurements of the discoloration include right ribs at 16 x 11.5cm, right hip at 12 x 8.5cm, right knee at 2 x 2cm, and right lateral ankle at 3.5 x 2cm. The FRI also showed, on 7/10/25 afternoon, V5 (CNA) reported that she transferred the resident by herself with the [mechanical lift brand name] in the afternoon. The FRI continued to show that upon interview, V5 stated she had forgotten to report a skin observation to the nurse, and denied there was any unusual occurrence during the transfer. The FRI report then showed V5 stated there was a possibility that the [mechanical lift brand name] lift arm that holds the sling, could have pressed up against the resident's rib area when she reached over to release the sling from the other side of the resident's body.On 7/29/25 at 9:30 AM, a skin check was done on R1. This writer observed mild greenish discoloration on the right hip area. On 7/29/25 at 11:00 AM, V3 (CNA) reported on 7/11/25 at around 9:30 AM, she noticed blackish purple bruises on R1 on her right flanks, right hip, right knee, and right ankle. V3 stated R1 had pain and tenderness at that time when V3 touched or turned her. On 7/29/25 at 11:50 AM, V3 (CNA), V4 (CNA), V7 (RN-Registered nurse) and V8 (RN) stated mechanical lift transfers must be done by two persons.On 7/29/25 at 12:35 PM, V6 (R1's Physician) stated, (R1) was on a blood thinning medicine, although the possibility of spontaneous bleed is mostly seen as an intra-cranial bleed or retro-peritoneal bleed. The CT (computed tomography) scan done for (R1) on 7/13/25 did not show any retroperitoneal or intracranial bleed, but it showed a sub-cutaneous bleed. (R1) probably has had an impact with a hard surface before 7/11/25, which led to the subcutaneous hematoma. Mechanical lift transfers must always be operated by two people for safe transfers.On 7/29/25 at 3:30 PM, V2 (DON-Director of Nursing) stated, (R1) probably hit a hard surface, though there are no witnesses to prove what happened. Otherwise (R1) would not have that pattern of bruises. It was something that could have been avoidable.On 7/29/25 at 1:10 PM V1 (Administrator) stated R1 definitely had some impact happened that should not have happened. V1 stated V5 (CNA) was terminated from the facility on 7/10/25. Facility's ‘safe resident handling' competency showed mechanical lift should have two people during the transfer.Prior to the survey of 7/30/2025, the facility had taken the following actions to correct the noncompliance:*Beginning 7/11/2025, the facility educated licensed and unlicensed regular/agency nursing staff on safe resident handling/transfers, following resident care plans for transfers, observation/reporting skin issues such as bruising and redness, and the facility abuse policy*Beginning on 7/11/2025, the facility conducted safe resident handling competencies for the use of mechanical lift and gait belt transfers for licensed and unlicensed nursing staff, including the use of two persons for mechanical lifts, and conducted resident skin review competencies for licensed and unlicensed nursing staff*On 7/11/2025, and impromptu QAPI meeting was held*From 7/13/2025 to 7/18/2025, twelve mechanical lift transfers were audited. Audits continued throughout the survey