STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146136	A. Building B. Wing	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Radford Green	960 Audubon Way Lincolnshire, IL 60069

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36186 Based on interview and record review the facility failed to ensure a resident (R1) was assessed in a timely manner after being lowered to the ground during a mechanical lift transfer on 7/26/24 at 5:30 AM which resulted in a left hip fracture. The facility failed to notify the physician in a timely manner and provide ongoing nursing assessments from the time of the incident on 7/26/24 at 5:30 AM through 8/1/24 when R1 was transported to the emergency department for evaluation and treatment of a left hip fracture. These failures resulted in R1 not receiving required medical evaluations and treatment after being lowered to the ground when she was falling from a mechanical lift on 7/26/24. This applies to one of three residents (R1) reviewed for injury in the sample of three. The findings include: The facility face sheet for R1 shows diagnoses to include fibromyalgia, Atrial Fibrillation, congestive heart failure and dementia. The facility assessment dated [DATE] shows R1 to have severe cognitive impairment and required maximum staff assistance with bed mobility and transfers. The final report dated 7/31/24 for a bruise of unknown origin shows upon further investigation it was discovered that the resident was being transferred by a sit to stand lift for a shower. During the transfer, R1 became agitated and began to come out of the sit to stand sling. The report shows this staff lowered the resident to the floor. The sling caused pressure to the left shoulder which developed into a bruise. An additional follow-up, post 5-day summary dated 8/2/24 shows R1 was noted with bruising to her left lower extremity and had an increase in pain. An x-ray revealed a fracture to the left distal femur. The undated facility final conclusion for bruise and fracture of unknown origin, upon completion of investigation shows it is believed that the left femur fracture is related to the reported incident of resident being lowered to the ground by staff on 7/26/24. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146136	A. Building B. Wing	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Radford Green	960 Audubon Way Lincolnshire, IL 60069

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 0684 Level of Harm - Actual harm Residents Affected - Few	On 8/7/24 at 3:00 PM, V5 (Certified Nursing Assistant/CNA) said he was the CNA caring for R1 on Friday 7/26/24. V5 said he was to give R1 a shower that morning. V5 said the shower began around 5:30 AM. After the shower was completed and he was preparing to transfer R1, she became agitated and resistive to having the lift sling placed under her arms. V5 said he proceeded with the transfer anyway and as the transfer was happening, she began to slide out of the lift sling. V5 said her legs were standing on the base of the lift and she never fell to the floor. V5 said he was alone during the transfer and knows he was to have assistance with the transfer. V5 said he did not report the incident to the nurse because R1 did not get hurt and he didn't feel he had to. V5 said R1 was lowered to the ground and a sling for the mechanical lift was placed under R1 as she lay on the floor, and she was lifted up off the floor into her wheelchair. On 8/7/24 at 6:39 PM, V6 (CNA) said on the morning of 7/26/24, at around 5:30 AM, she heard yelling from the shower room and noticed the door was ajar. V6 said when R1 gets a shower, she does yell out loudly. V6 said she wanted to close the door to avoid disrupting the other residents in the unit. V6 said she peeked in the room and saw R1 hanging from the sit to stand lift sling with her arms raised high and her legs dangling near the ground. V6 said R1 was not bearing any weight on her legs at the time. V6 said V5 (CNA) was just standing there looking at R1 with a shocked look on his face. V6 said V5 was not doing anything to help R1. V6 said she immediately went into the room, told V5 to grab R1 from behind and support her weight and V6 lowered the lift arm and detached the arm sling from R1 and V5 lowered R1 to the ground. V6 said V5 did not have the leg band secured around R1's legs. V6 said she went and got the mechanical lift and together her and V5 rolled R1 onto a sling and lifted her off the floor and into her wheelchair. V6 said she knew the incident should have been reported to the nurse and she assumed V5 would do that. On 8/8/24 at 9:45 AM, V3 (Director of Nursing) said a bruise of unknown origin was reported to her on 7/27/24 to R1's left shoulder. V3 said an investigation was started and it was discovered R1 was lowered to the ground on 7/26/24 in the shower room. V3 said bruising and resident complaints of pain were to her left shoulder only, until on 8/1/24 when bruising and limited range of motion was observed for R1. An x-ray revealed a fracture to R1's left femur. V3 said R1 was not complaining of any pain to her leg in the week between the incident and when the fracture was identified. V3 said she expects staff to have two CNA's present for all transfers involving a mechanical lift. V3 said this is for the safety of the resident. One staff to run the lift and another staff to guide and protect the resident. V3 said the staff should have gotten the nurse before moving the resident so an assessment could have been completed to check for injuries. On 8/8/24 at 2:13 PM, V10 (Advanced Practice Nurse) said when R1 was lowered to the ground on 7/26/24, it should have been reported to the nurse right away so an assessment for injuries could have been performed. V10 said she expects the staff to perform an assessment to check for any acute injuries and the resident should be closely monitored for at least 24 hours after an incident. On 8/8/24 at 5:27 PM, V13 (Orthopedic Surgeon) said R1 had very poor bone quality so being lowered to the ground during a transfer could have led to this type of fracture. V13 said R1 had a bad injury, and she should have been sent out to the emergency department after the incident for x-rays and treatment. The x-ray report dated 8/2/24 (seven days after the incident of being lowered to the ground) shows R1 had a fracture of the distal shaft (lower) of the left femur (thigh bone) with some overriding of the fracture fragments. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146136	A. Building B. Wing	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Radford Green	960 Audubon Way Lincolnshire, IL 60069

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 0684 Level of Harm - Actual harm Residents Affected - Few	The nursing progress note dated 8/1/24 at 12:55 AM, shows R1 was experiencing restricted range of motion to her lower extremities. R1 would scream in pain when leg was moved, substantial swelling to the entire leg and R1 not able to tolerate leg extension, flexion, or elevation. On the same day at 7:46 AM, it was documented in R1's records that R1 now had discoloration on the back of her leg and back of the knee. The hospital emergency department report dated 8/2/24 shows R1 had a fall reportedly one week ago and the details of the fall were unknown. R1's left leg was swollen with tenderness and bruising noted to the back of the leg and painful range of motion. The x-ray of the left leg showed a closed fracture of the distal end of the left femur. The hospital progress note dated 8/2/24 completed by the Orthopedic surgeon showed the left lower is shortened and R1 grimaces when the leg was palpated. The facility falls clinical protocol assessment and recognition revised March 2018 shows the nurse shall assess and document/report the following: vital signs, recent injury, observe for change in normal range of motion, weight bearing, change in cognition or level of consciousness, neurological status, pain, precipitating factors, details on how the fall occurred .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146136	A. Building B. Wing	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Radford Green	960 Audubon Way Lincolnshire, IL 60069

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 - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36186 Based on interview and record review the facility failed to safely transfer a resident using a mechanical lift. This failure resulted on R1 sustaining a femur fracture requiring surgery. This applies to one of three residents reviewed for safety in the sample of three. The findings include: The facility face sheet for R1 shows diagnoses to include fibromyalgia, Atrial Fibrillation, congestive heart failure and dementia. The facility assessment dated [DATE] shows R1 to have severe cognitive impairment and required maximum staff assistance with bed mobility and transfers. The final report dated 7/31/24 for a bruise of unknown origin shows upon further investigation it was discovered that the resident was being transferred by a sit to stand lift for a shower. During the transfer, R1 became agitated and began to come out of the sit to stand sling. The report shows this staff lowered the resident to the floor. The sling caused pressure to the left shoulder which developed into a bruise. An additional follow-up, post 5-day summary dated 8/2/24 shows R1 was noted with bruising to her left lower extremity and had an increase in pain. An x-ray revealed a fracture to the left distal femur. On 8/7/24 at 12:55 PM, V1 (Administrator) said for the resident's safety during a mechanical lift transfer, there must be two staff present. On 8/7/24 at 3:00 PM, V5 (Certified Nursing Assistant/CNA) said he was the CNA caring for R1 on Friday 7/26/24. V5 said he was to give R1 a shower that morning. V5 said the shower began around 5:30 AM. After the shower was completed and he was preparing to transfer R1, she became agitated and resistive to having the lift sling placed under her arms. V5 said he proceeded with the transfer anyway and as the transfer was happening, she began to slide out of the lift sling. V5 said her legs were standing on the base of the lift and she never fell to the floor. V5 said he was alone during the transfer and knows he was to have assistance with the transfer. On 8/7/24 at 6:39 PM, V6 (CNA) said on the morning of 7/26/24, at around 5:30 AM, she heard yelling from the shower room and noticed the door was ajar. V6 said when R1 gets a shower, she does yell out loudly. V6 said she wanted to close the door to avoid disrupting the other residents in the unit. V6 said she peeked in the room and saw R1 hanging from the sit to stand lift sling with her arms raised high and her legs dangling near the ground. V6 said R1 was not bearing any weight on her legs at the time. V6 said V5 (CNA) was just standing there looking at R1 with a shocked look on his face. V6 said V5 was not doing anything to help R1. V6 said she immediately went into the room, told V5 to grab R1 from behind and support her weight and V6 lowered the lift arm and detached the arm sling from R1 and V5 lowered R1 to the ground. V6 said V5 did not have the leg band secured around R1's legs. V6 said she went and got the mechanical lift and together her and V5 rolled R1 onto a sling and lifted her off the floor and into her wheelchair. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146136	A. Building B. Wing	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Radford Green	960 Audubon Way Lincolnshire, IL 60069

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 - Actual harm Residents Affected - Few	On 8/8/24 at 9:45 AM, V3 (Director of Nursing) said a bruise of unknown origin was reported to her on 7/27/24 to R1's left shoulder. V3 said an investigation was started and it was discovered R1 was lowered to the ground on 7/26/24 in the shower room. V3 said bruising and resident complaints of pain were to her left shoulder only, until on 8/1/24 when bruising and limited range of motion was observed for R1. An x-ray revealed a fracture to R1's left femur. V3 said R1 was not complaining of any pain to her leg in the week between the incident and when the fracture was identified. V3 said she expects staff to have two CNAs present for all transfers involving a mechanical lift. V3 said this is for the safety of the resident. One staff to run the lift and another staff to guide and protect the resident. On 8/8/24 at 5:27 PM, V13 (Orthopedic Surgeon) said R1 had very poor bone quality so being lowered to the ground during a transfer could have led to this type of fracture. The x-ray report dated 8/2/24 shows R1 had a fracture of the distal shaft (lower) of the left femur (thigh bone) with some overriding of the fracture fragments. The nursing progress note dated 8/1/24 at 12:55 AM, shows R1 was experiencing restricted range of motion to her lower extremities. R1 would scream in pain when leg was moved, substantial swelling to the entire leg and R1 not able to tolerate leg extension, flexion, or elevation. On the same day at 7:46 AM, it was documented in R1's records that R1 now had discoloration on the back of her leg and back of the knee. The undated facility final conclusion for bruise and fracture of unknown origin, upon completion of investigation shows it is believed that the left femur fracture is related to the reported incident of resident being lowered to the ground by staff on 7/26/24. The facility policy with a revision date of March 2024 for lifting machine, using a mechanical lift shows at least two nursing assistants or nurse are needed to safely move a resident with a mechanical lift.