Illinois Department of Public Health

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 06/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLNWOOD PLACE	7000 NORTH MCCORMICK BLVD. LINCOLNWOOD, IL 60645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Facility Incident Report Investigation of 4/28/21/ IL00133524	S 000		
S9999	Final Observations Statement of Licensure Violations: 330.710 a) 330.1145 c) 330.4240 a) 330.4240 b) 330.4240 e) Section 330.710 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 with the involvement of the administrator. The written policies shall be followed in operating the facility and shall be reviewed at least annually by the Administrator. Section 330.1145 Restraints c) Physical restraints shall only be used in an emergency as specified in Section 330.1150. Section 330.4240 Abuse and Neglect a) An owner, licensee, administrator, employee of a facility shall not abuse or neglect a resident. b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long term care facility is the perpetrator of the abuse that employee shall	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigations, prosecution or disciplinary action against the employee. This requirement is NOT MET as evidenced by; Based on interview and record review, the facility failed to provide a safe environment free from abuse and failed to follow their Abuse and Neglect Policy and Procedure, for one resident (R1), in a sample of three reviewed for abuse. Findings include: On 6/28/21 at 12:07pm, V3 (Memory Care Director) said that on the morning of 4/28/21 during her rounds of the unit, she found R1's bed surrounded with furniture. "On the side of the bed was the couch and in the other side, were two arm chairs. So it was set up like a crib. Resident would not be able to get out of bed with the furniture surrounding him." V3 said incident was reported to V1 (Administrator), "Because he (R1) was entrapped in there." On 6/28/21 at 1:39pm, V4 (Registered Nurse) said she also noticed the chairs surrounding the bed, and with the help of anther staff, removed the furniture surrounding R1's bed. On 6/29/21 at 12:13pm, V1 said V8, Certified Nursing Assistant, admitted she put the furniture around the resident's bed and knew it was wrong. V8 was terminated by facility. On 6/28/21 at 3:37pm, V2 (Director of Nursing) was asked if it's right for V8 to put furniture around the resident's bed. V2 answered, " No because it was creating restraint preventing	S9999		

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S9999	Continued From page 2 resident's movement without a consent. Nurse involved in the incident should have not allowed it to happened and the should have reported it to us immediately " On 6/28/21 at 11:50am, V1 clarified the incident happened on the night shift (4/27 /21 11:00pm-to 4/28/21 7:00am). V1 said V9 (Licensed Practical Nurse) was the nurse on duty at the time of incident. V9 was interviewed about the incident prior to 4/28/21 11:00pm shift. At that interview, V9 told V1 he did not see R1 surrounded with furniture because he was not making rounds as he was supposed to do. Despite this statement, the facility allowed V9 to work on 4/28/21 11:00pm- 4/29/21 7:00am shift. Per V9's time sheet, V9 clocked in on 4/28/21 at 10:06pm, and clocked out on 4/29/21 at 7:45am. V1 said after further investigation and staff interview, on the morning of 4/29/21 after V9's shift, V9 admitted to knowing what was going on and was suspended. On 4/30/21 V9 was terminated. On 6/29/21 at 9:41am, V2 stated her expectations of the nurse with regards to rounding. "Nurse and CNAs are expected to rounds hourly at minimum." Policy and Procedure for rounding was requested. None provided. Facility document titled Job Title: LPN (Licensed Practical (Vocational) Nurse) Position Summary: This position reports to the Director of Nursing and may be required to supervise other staff positions. Essential Functions: Strives to maintain a safe working environment through the prevention of accidents .....and the achievement of safe working practices.	S9999		

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S9999	Continued From page 3 Policy and Procedure titled Abuse Investigation -Skilled dated 4/18/2019: The employee/employees involved will be placed on immediate suspension, until completion of the investigation, once their statement regarding the incident has been obtained. (B)	S9999		